SUBCOMMITTEE NO. 3 Agenda
Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Denise Ducheny

Senator Wesley Chesbro
Senator Dave Cox

May 19th, 2006

11:00 PM

Room 4203

May Revision and Remaining Issues

(Diane Van Maren)

Item	Department
4280	Managed Risk Medical Insurance Board
4260	Department of Health Services
4120	Emergency Medical Services Authority *(Jointly heard with DHS)*
4300	Department of Developmental Services
4440	Department of Mental Health

PLEASE NOTE:

(1) ALL previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at the May Revision hearing.

(2) The "VOTE ONLY" CALENDAR for each department may include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable.

(3) Only those issues in today's agenda are before the Subcommittee.

(4) Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

I. ISSUES RECOMMENDED FOR "VOTE ONLY" *(Through to Page 17)*

A. Item 4280--Managed Risk Medical Insurance Board *(Vote Only)*

1. Access for Infants and Mothers (AIM) Program (issues 121 and 122)

Governor's May Revision. A total of $120.4 million ($51.8 million Perinatal Insurance Fund and $68.6 million federal funds) is proposed for AIM in 2006-07. **This funding level reflects an increase of $5.9 million (total funds) over the January budget.** The increased cost reflect infants being transitioned out of AIM and enrolled directly into the Healthy Families Program, leaving a larger share of relatively higher cost pregnant women in the AIM Program.

With a declining number of infants/toddlers enrolled in AIM, the Managed Risk Medical Insurance Board has had to increase provider rates to recognize the relatively higher cost of pregnancies for a higher share of the caseload. The average capitation fee for pregnant women has been revised to $9,530 (one-time capitation fee) based on the negotiated rates and projected enrollment plan. This rate is $619 or almost 7 percent higher than the rate used for the January budget.

Average monthly enrollment is expected to be 1,616 women and infants, or about 5 percent lower than assumed in the January budget. About 12,211 pregnant women will in enroll in AIM for the budget year.

Additional Background Information. The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.

As of July 1, 2004, infants born to AIM women are automatically enrolled in the Healthy Families Program (HFP) at birth. Infants born during 2004-05 to AIM mothers who enrolled in AIM prior to July 1, 2005 will remain in AIM through two years of age. Therefore, infant enrollment is declining and shifting to the HFP. This is because infants will age out of the AIM Program at two years old while no new infants will be enrolled after July 1, 2004, unless the AIM mother was enrolled prior to that date. **Therefore, the AIM Program is transitioning to focusing only on pregnant women and 60-day post partum health care coverage.**

Subcommittee Staff Recommendation. It is recommended to approve the May Revision. The cost increase is due to new negotiated rates which have been approved by the Managed Risk Medical Insurance Board. No issues have been raised.

2. County Health Initiative Matching Fund (CHIM) Program (issue 120)

Governor's May Revision. The May Revision proposes an increase of $156,000 ($101,000 federal funds and $55,000 County Health Initiative Matching Fund) for total expenditures of $3.9 million ($2.5 million federal and $1.4 million County Health Initiative Matching Fund).

The May Revision reflects a revised estimate for the CHIM Program. Specifically, the MRMIB assumes an enrollment level of 3,015 children (35,712 enrollment months), which reflects an increase of 48 children as compared to the January budget. The pilot counties include Alameda, Santa Clara, San Mateo, San Francisco, Santa Cruz and Tulare.

It should be noted that the enabling legislation for the program clearly notes that the federal S-CHIP funds made available for this program are provided only because they are not being used for the state's Healthy Families Program. In the event the federal funds are needed to support the Healthy Families Program, these programs would be scaled back under existing law.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allows county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for four pilot counties (i.e., Alameda, San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties (i.e., Santa Cruz and Tulare) in 2005-06.

Subcommittee Staff Recommendation. It is **recommended to approve the May Revision**. No issues have been raised.

B. Item 4260 — Department of Health Services *(Vote Only)*

1. Child Health Disability Prevention (CHDP) Program (issue 513)

Governor's May Revision: The **May Revision proposes total expenditures of $3.4 million** ($3.4 million General Fund and $24,000 Childhood Lead Poisoning Prevention Funds) for the program. **This reflects a decrease of almost $300,000 ($219,000 General Fund).**

The program will provide about 50,544 health screens for children. This reflects a decrease of 5,156 screens as compared to the January budget.

No policy changes are proposed.

Subcommittee Staff Recommendation: It is recommended to **adopt the May Revision.** No issues have been raised.

Overall Background: The Child Health Disability Prevention (CHDP) Program provides pediatric prevention health care services to **(1)** infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and **(2)** children and adolescents who are eligible for Medi-Cal services up to age 21 (Early Periodic Screening Diagnosis and Treatment—EPSDT). CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health examination certificate or an equivalent examination to enroll in school.

The benefit package provided under the *CHDP-only* program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up.

2. Genetically Handicapped Persons Program (GHPP) (issue 514)

Governor's May Revision. The May Revision **proposes total expenditures of $51.3 million for a *reduction* of $4.3 million ($3.1 million General Fund) as compared to the January budget.** Of the total amount appropriated for the program, $45.8 million (total funds) is used to support individuals with Hemophilia by providing blood factor product and related assistance. Part of this reduced cost is attributable to a reduction in caseload as compared to January (about 31 cases less is projected).

As discussed in a prior Subcommittee hearing, the GHPP will now be participating in the Medi-Cal rebate program for blood factor product. **As such, it is assumed that rebates will increase by about $3.2 million which will be used to offset General Fund support.**

Subcommittee Staff Recommendation: It is recommended to **adopt the May Revision** as proposed. It should be noted that a prior Subcommittee action to adopt placeholder trailer bill language to provide access to the Medi-Cal rebate program for the GHPP will remain. Subcommittee staff will be working with the Administration to finalize this language.

Overall Background: The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially ineligible for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fee and treatment costs based on a sliding fee scale for family size and income.

3. California Children's Services (CCS) Program (issue 512)

Governor's May Revision: The May Revision proposes total expenditures of $208.3 million ($49 million General Fund) which reflects an increase of $12.1 million ($4.5 million General Fund). Most of this increase is attributable to infants born into the AIM and HFP programs that have CCS-eligible conditions and therefore need specialized CCS Program medical services. In addition, it is estimated that 649 more children will need services in 2006-07 (total of 39,446 children). Medical therapy costs have also increased as compared to January.

The May Revision also reflects several shifts in funding sources. The Administration proposes to no longer use federal Title V Maternal and Child Health (MCH) grant funds for the program due to the recent reduction in California's grant. Also, as discussed in a prior Subcommittee hearing, federal funds obtained under the newly implemented Medi-Cal Hospital Waiver Program are to be used for the CCS Program. The May Revision reflects a total of $53.3 million (federal funds) from this funding source which reflects an increase of $6.3 million as compared to January.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

Overall Background on CCS: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are

provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.

4. Genetic Disease Screening Programs (issue 511)

May Revision. The May Revision **provides a total increase of $8.587 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Programs (the Newborn Screening Program and the Prenatal Screening Program) as compared with the January budget.**

Specifically, the May Revision proposes the following for each program:

- *Newborn Screening Program.* A total of $36.8 million (Genetic Disease Testing Fund) is proposed for this program which reflects an increase of $6.6 million (Genetic Disease Testing Fund) over the January budget. This increase is primarily due to increased expenditures in the technical and scientific contracts and laboratory contracts.

  The cost per screen is $46 and the number of tests anticipated to be provided is 566,916. No fee increases are proposed for this existing program.

  The average cost per case for follow-up, referral, and counseling can vary from year to year, contingent upon the needs identified. For example, in 2004-05 the average cost was $941 dollars per case (3,775 cases), in 2005-06 it was $678 per case (6,732 cases), and in 2006-07 it is estimated at $836 dollars per case (6,793 cases). No additional fee is charge for this follow-up assistance.

- *Prenatal Screening Program.* A total of $31.9 million (Genetic Disease Testing Fund) is proposed for this program which reflects an increase of almost $2 million (Genetic Disease Testing Fund) over the January budget. This increase is primarily due to increased expenditures in the technical and scientific contracts, and laboratory contracts, as well as in follow-up costs. The cost per screen is $21.98 which reflects an increase of 52 cents as compared to 2005-06.

Background--Summary of Programs. The Newborn Screening Program provides screening of all newborns for genetic and congenital disorders that are preventable or remediable by early intervention. The Prenatal Screening Program provides screening of pregnant women who consent to screening for serious birth defects. The screening programs provide public education, laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. The programs are self-supporting on fees collected from screening participants through

the hospital of birth, third party payers or private parties using a special fund—Genetic Disease Testing Fund.

Subcommittee Staff Recommendation. It is **recommended to approve** the May Revision.

5. Augmentation for the Alzheimer's Research Centers (issue 366)

May Revision. The May Revision proposes an increase of $2 million (General Fund) to increase the grants provided to the 10 Alzheimer's Research Centers of California (Centers). These funds are to be used to continue diagnostic, education and consultation services, and to expand clinical research.

The Centers are currently funded at $4 million so this augmentation provides a 50 percent increase in funding. The funding is appropriated to the DHS and is distributed through grants to each of the 10 Centers. The augmentation will provide an additional $185,000 to each of the Centers. The remaining $150,000 will be provided to UC San Francisco (Institute for Heath and Aging). The last augmentation provided to the Centers was in 1998-99.

Background. The Alzheimer's Research Centers were created through funding established in 1984 for the Alzheimer's Disease Program to (1) provide diagnostic and treatment services to improve the quality of care for persons with this disease, (2) conduct research directed towards the cause and cure of Alzheimer's, and (3) provide training and consultation for professionals in-training and for families and caregivers.

Subcommittee Staff Recommendation. It is recommended **to approve** the May Revision.

6. Align Federal Authority to Match Federal Bioterrorism Grant Awards (issue 362)

May Revision. The May Revision **proposes to reduce by $6.975 million (federal funds) and 6 vacant positions to accurately align federal grant awards with the state budget appropriation authority.**

The current federal grant award to California is $103.8 million (federal funds) which represents a reduction of $6.975 million from the existing state budget authority of $110.775 million. The Administration notes the federal grant awards have been declining since the initial grant authorization provided in 2000-01.

This proposal addresses the inflated budget authority by reducing it to a level of anticipated federal funding.

Subcommittee Staff Recommendation. It is **recommended to approve** the May Revision. No issues have been raised.

7. Conforming Action to Senate Subcommittee #2—Shift Positions to the DHS

Senate Budget Subcommittee No. 2 Action. On May 8, Senate Budget Subcommittee #2 rejected the Governor's Finance Letter proposal and instead recommended transferring the positions that support specific programs within the CALFED program back to the departments that implement the programs. The **Department of Health Services** is an implementing agency for the CALFED Drinking Watery Quality Program.

The Senate Budget Subcommittee No. 2 has recommended moving two positions and $253,000 in General Fund monies from the Bay-Delta Authority to the Department of Health Services to support development of performance measures, strategic planning, drinking water data model development and science to support the CALFED Drinking Water Quality Program. The Department of Health Services currently has $125,000 and one position funded by Proposition 50 bond funds in its Division of Drinking Water and Environmental Management to support development of a regional strategic framework, performance measures and conceptual models.

Subcommittee Staff Recommendation. Staff recommends that the Subcommittee approve $253,000 from the General Fund and two positions to accommodate the transfer of two positions currently established at the Bay-Delta Authority to conform.

Finance Letter. A Finance Letter (dated April 18, 2006) proposes to transfer 68 of the 71 existing positions from the California Bay-Delta Authority to the Office of the Secretary for Resources. This proposal includes two positions that have been working on drinking water quality issues.

Background. The CALFED Bay-Delta Program (CALFED), a consortium of 12 state and 13 federal agencies, was created to address a number of interrelated water problems in the state's Bay-Delta region. Over the last year the Administration undertook a comprehensive program, fiscal and governance review of the CALFED Bay-Delta Program, which found serious deficiencies in the program and in its governance. Recently, the administration released a 10-Year Action Plan that proposes further study and reorganization.

8. Caseload Adjustments for Cancer Detection—"Every Woman Counts" (issue 367)

Governor's May Revision. The May Revision proposes an increase of $4.1 million (Proposition 99 Funds) to the Every Woman Counts" Program due to (1) a reduction of $2.650 million in federal grant funds, and (2) an increase in caseload (263,066 screenings to 272,410 screenings for women) and related technical adjustments. Proposition 99 Funds (Unallocated Account) are presently used for this purpose.

Subcommittee Staff Recommendation. It is recommended to adopt the May Revision. No issues have been raised.

9. Administration's Technically Modified Proposition 99 TBL for Emergency Physicians

Governor's May Revision. The May Revision makes a technical conforming change to language that was approved by the Subcommittee in a prior hearing.

Subcommittee Staff Recommendation. It is recommended to adopt the minor change. No issues have been raised and staff also discussed this issue with affected constituency groups.

C. Item 4300 — Department of Developmental Services *(Vote Only)*

1. Adjustment to Prior Subcommittee Action—RC Contract Language (issue 223)

Prior Subcommittee Actions (April 3rd Hearing—Rejected Proposal). In a prior Subcommittee hearing action was taken to reject the Governor's January budget proposal to make extensive Regional Center contract language changes to reduce services and supports provided to consumers served by Regional Centers. The rejection of this budget proposal, and corresponding trailer bill language, resulted in (1) a decrease of $7.6 million (General Fund) for RC Operations, and (2) an increase of $14.3 million ($10.6 million General Fund). **The Legislature has rejected this proposal four years in a row.**

Subcommittee Staff Recommendation (Reject and Adjust Fiscal for May Revision). Since the Governor's May Revision continues this reduction to consumer services, **it is recommended to update the Subcommittee's prior action (i.e., rejection of the proposal) to reflect technical fiscal changes. Specifically, it is recommended to (1) decrease by $7 million (General Fund) for RC Operations, and (2) increase by $14.7 million ($10.9 million General Fund) the RC Purchase of Services.**

Additional Background—Governor's RC Contract Language for Expanded Cost Containment. The Governor's May Revision maintains his January budget proposal to make substantial policy changes by modifying the state's contract with Regional Centers to require them to apply new restrictions on consumers at the time of their Individual Program Plan (IPP) development or scheduled review.

The May Revision assumes a reduction of $14.7 million ($10.9 million General Fund) in the RC Purchase of Services, and an increase of $7 million (General Fund) to expand RC Operations related to controlling the purchase of services and supports by consumers. An individual's IPP is to be reviewed no less than once every three years. As such, the budget assumes that one-third of the consumer's would have their plans reviewed each year. **As noted in the table below, full implementation would be achieved in 2008-09.**

Table: Summary of Governor's Reduction's to RC Purchase of Services (May Revision)

Fiscal Year and Cumulative Effect	Reduction To Services (Total Funds)	Proposed General Fund Savings
2006-07 One-third of population is reviewed.	$14.7 million	$10.9 million
2007-08 Continue 2006-07 savings and review next one-third of population.	$29.5 million	$21.9 million
2008-09 Continue 2006-07 and 2007-08 savings and review next one-third of population.	$44.2 million	$32.8 million

The Governor's proposed Purchase Of Services requirements are as follows:

- *1. Vendor Selection Based On Lowest Cost:* The cost of providing services by different vendors, if available, would be reviewed by an RC and the least costly vendor who is able to meet the consumer's needs, as identified in the consumer's IPP, would be selected.

- *2. Statement of RC Services:* RCs would annually provide the consumer or their parent/guardian a statement of RC purchased services and supports. This statement would include the type, unit, and cost of the services and supports. This provision of the guidelines is intended to serve as a validation that the described services and supports are indeed being provided to the consumer by the designated vendor.

- *3. Directs RCs to Adhere to Existing Laws and Regulations In Purchasing Services:* RCs would be directed to establish internal processes to ensure that (1) their staff is following all laws and regulations when purchasing services and supports for consumers, and (2) other services, such as generic services provided by other agencies in the community, are pursued and used prior to authorizing the expenditure of RC funds for consumers.

- *4. Services to a Minor Child:* Under the Governor's proposal, legislation would be enacted to require RCs to take into account the family's responsibility for providing similar services to a minor child without disabilities when determining which services or supports would be purchased by the RC for the child.

- *5. RC Clinical Review:* RCs would be required to have a clinician review all requests for certain services and supports prior to the RC authorizing their purchase for the consumer. This review would pertain to certain supplemental program supports, assistive technology and environmental adaptations, behavioral services, specialized medical or dental services, and therapeutic services.

- *6. Use of Group Modality:* RCs would be directed to give preference for purchasing a service or support using a group modality, in lieu of an individual intervention, if a consumer's needs, as identified in their IPP, could be met using a group modality for the following services: Behavioral Services, Social and Recreation Activities, and Non-Medical Therapy Services.

2. Best Buddies Program

Issue. The Best Buddies Program is presently funded at $1 million (General Fund). This program provides services through the Regional Centers to children and adolescents. It has not received an increase for many years and could expand to other areas of the state if an augmentation is provided.

Subcommittee Staff Recommendation. It is **recommended to increase the Best Buddies Program** by $500,000 (General Fund).

D. Item 4440 — Department of Mental Health *(Vote Only)*

1. Healthy Families Program—*Supplemental Mental Health Services* (issue 150)

Governor's May Revision: The May Revision **proposes an increase of $1.1 million (Reimbursements from the MRMIB) to primarily reflect technical caseload adjustments to the HFP supplemental mental health services**. This adjustment is due to updated paid claims data and county administration adjustments.

Subcommittee Staff Comment and Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match. With respect to legal immigrant children, the state provides 100% General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a supplemental program to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The supplemental services provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available.

2. Adjustments for San Mateo Pharmacy and Laboratory Services (issue 160)

Governor's May Revision. The May Revision proposes a decrease of $4.6 million ($2.6 million General Fund) to reflect adjustments to this project. Most of this adjustment is attributable to the full year impact of the Medicare Part D Drug Program.

Subcommittee Staff Recommendation. It is **recommended to adopt the May Revision.** No issues have been raised.

Additional Background—What is the San Mateo Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute since 1995. **San Mateo is the only county that has responsibility for the management of some financial risk and the management of pharmacy and related laboratory services, in addition to being responsible for psychiatric inpatient hospital services and outpatient specialty mental health services.**

This project is intended to test managed care concepts which may be used as the state progresses towards the complete consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the San Mateo Project has matured and evolved, additional components have been added and adjusted.

Additional Background—What is the San Mateo Field Test Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" project since 1995. San Mateo is the only county that has responsibility for the management of some financial risk through a case rate system and the management of pharmacy and related laboratory services, in addition to being responsible for psychiatric inpatient hospital services and outpatient specialty mental health services.

The field test is intended to test managed care concepts which may be used as the state progresses towards the complete consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the San Mateo Field Test Project has matured and evolved, additional components have been added and adjusted.

3. Mental Health Managed Care Adjustments (issue 140)

Governor's May Revision The May Revision reflects two adjustments—one to local assistance and the other to state support. For local assistance, a reduction of $1 million ($509,000 General Fund) is proposed. For state support, an increase of $106,000 (General Fund) is made which reflects a technical transfer of funds from the Department of Health Services appropriation to the DMH.

The $1 million ($509,000 General Fund) reduction in local assistance is primarily due to a decrease in the number of Medi-Cal eligibles obtaining services.

Subcommittee Staff Recommendation. It is **recommended to adopt the May Revision.** No issues have been raised.

Background—Overview of Mental Health Managed Care: Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government. Medi-Cal recipients *must* obtain their mental health services through the County MHP.

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements.

Background—How Mental Health Managed Care is Funded: Under this model, County MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. **County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.**

An annual state General Fund allocation is also provided to the County MHP's. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items.

The state's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

4. Governor's Homelessness Initiative Phase II (Proposition 63) (issue 303)

Governor's May Revision. The **May Revision proposes an increase of $1.2 million to provide administrative support to implement the Governor's Homelessness Initiative Phase II (permanent supportive housing).** Specifically, these funds will be used to **(1)** hire three Associate Mental Health Specialists, and **(2)** hire consultants to do a variety of functions related to housing assistance. These dollars are considered state support and must therefore be appropriated through the budget process. (All local assistance for this project--$75 million--, as well as all other Proposition 63 local assistance is continuously appropriated. As such there is no annual appropriation through the Budget Act.)

Subcommittee Staff Recommendation. It is **recommended to approve the proposal for the state funding. No issues have been raised.**

5. Proposition 63—Oversight and Accountability Commission Adjustment (issue 300)

Governor's May Revision. The May Revision proposes an increase of $534,000 (Mental Health Services Fund—Proposition 63) to support the activities of the Oversight and Accountability Commission (Commission). Specifically, $226,000 is to be used for specified contracts and the remaining amount is to make technical adjustments for expenditures relating to changes in personnel classifications that were just approved, telecommunications, printing and reproduction, stakeholder involvement, travel and other such items.

Subcommittee Staff Recommendation. It is recommended **to approve the May Revision**. No issues have been raised.

Background—Oversight and Accountability Commission. The Commission, as stated in the Proposition, has the following responsibilities:

- Oversee the implementation of the Mental Health Services Act (MHSA) regarding (1) community services and supports, (2) education and training, (3) innovative programs, and (4) prevention and early intervention;
- Develop strategies to overcome stigma and accomplish all objectives of innovative programs and prevention and early intervention programs;
- Review and approve all county mental health program expenditures for innovative and prevention and early intervention programs; and
- Ensure the perspective of mental health clients and their family members is a significant factor in all recommendations for MHSA implementation.

The Commission consists of 16 voting members comprised of the following: (1) the Attorney General or designee; (2) Superintendent of Public Instruction or designee, (3) Chairperson of Senate Health and Human Services Committee; (4) Chairperson of Assembly Health and Human Services Committee; and (5) 12 members appointed by the Governor.

The Commission has both general and specific responsibilities with regard to oversight of expenditures of MHSA Funds. It is statutorily mandated to review, approve, and determine mechanisms to provide close oversight on all county plans in the area of prevention, early intervention and innovation (20 percent of the funds). They must develop strategies to overcome stigma related to mental illness, inform the Governor and Legislature about mechanisms to improve mental health care in California, work closely with clients of CA public mental health system and their family members and establish technical advisory committees so that consumers and family members can play an integral role in shaping recommendations. The Commission meets on a monthly basis. In addition, there are presently 7 subcommittees working on a variety of select issues related to the act and its functions.

6. Implementation of the Conlan Court Order (Medi-Cal Recipients) (issue 302)

Governor's May Revision. The May **Revision proposes a *one-time only* increase of $3.318 million ($1.6 million General Fund) to comply with the requirements of the Conlan Court Order (*Conlan v. Shewry*).** Several departments are affected by this DHS lawsuit.

The DMH requested amount is based on assumptions agreed to jointly by the Administration across several departments. The request of $3.318 million equates to half of the total estimate of retroactive and co-pay claims. In addition, the DMH proposes to utilize part of the funding to contract with an organization to process the retroactive/co-pay claims and to coordinate the reimbursement of those claims.

The DMH must process claims from Medi-Cal beneficiaries who had unreimbursed expenditures for medical expenses **(1)** during the three-month period prior to applying for Medi-Cal benefits if determined eligible during that period, **(2)** during the period that an application for Medi-Cal was pending, and **(3)** during the period between a denial of their application for eligibility and reversal

of that decision. In addition, it also applies to Medi-Cal beneficiaries with other health coverage that erroneously paid excess co-payments to a provider.

Subcommittee Staff Recommendation. It is **recommended to adopt the May Revision.** No issues have been raised. The state must comply with the court order by October 2006 or face sanctions. (The Department of Health Services is the lead state entity.)

Background—Conlan v. Shewry. This lawsuit has a long history resulting in the issuance of several court decisions. The first decision was issued in 2002 and directed the DHS to adopt and implement procedures to ensure that Medi-Cal recipients entitled to reimbursement for covered services obtained during the "retroactive period" (defined as the three-month period prior to application for Medi-Cal) are promptly reimbursed.

Now, as ordered in May 2006 the court ordered that the DHS must have a reimbursement process fully implemented by October 2006. Failure to meet this deadline would result in contempt sanctions by the court against the DHS.

Since these issues pertain to the Medi-Cal Program and Medi-Cal beneficiaries, the court ruling affects several departments, including the DMH.

7. Forensic Conditional Release Program (issue 110)

May Revision. The May Revision is requesting **an increase of $456,000 (General Fund)** for the Forensic Conditional Release Program to reflect an increase in the number of patients being discharged that are expected to be in the Conditional Release Program (CONREP) in 2006-07. **According to the DMH, a total of $22.7 million (General Fund) is needed for the program in 2006-07, including all ancillary contracts, which reflects an increased need of $456,000 to provide for 20 additional patients and a slightly increased cost per patient.** It is assumed that 740 total patients will use CONREP.

Subcommittee Staff Recommendation. No issues have been raised regarding the Administration's proposal. It is **recommended for approval.**

Background. This program provides for (1) outpatient services to patients into the Conditional Release Program (CONREP) via either a court order or as a condition of parole, and (2) hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually enter CONREP. The patient population includes: (1) Not Guilty by Reason of Insanity, (2) Mentally Disordered Offenders, (3) Mentally Disordered Sex Offenders, and (4) Sexually Violent Predators. The DMH contracts with counties and private organizations to provide these mandated services in the state, although patients remain DMH's responsibility per statute when they are court-ordered into CONREP community treatment and supervision.

The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, and certain screening and diagnostic tools. Supervision and monitoring tools include

Global Positioning System (GPS), polygraphs, substance abuse screening, and collaboration with law enforcement.

8. Required Evaluations for Sexually Violent Predators (issue 120)

Governor's May Revision. The May Revision is requesting **an increase of $548,000 (General Fund) to reflect an increase in the number of SVP evaluations to be performed by private contractors, as well as costs for evaluator court testimony.** The DMH is continuing to use a one-year regression analysis of the most recent billing data in developing the costs for SVP evaluations and court testimony. They believe this method serves as the most accurate predictor of costs at this time. The total amount for these activities in 2006-07 would be $5.422 million (General Fund).

The table below summarizes the May Revision changes as compared to the January budget.

SVP Program Evaluation & Court Estimate	2006-07 January	**May Revision**	**Difference**
Initial Evaluations	$1,798,000	$2,271,000	$473,000
Initial Court Testimony	348,000	139,000	-209,000
Evaluation Updates	323,000	218,000	-105,000
Recommitment Evaluations	705,000	1,347,000	642,000
Recommitment Court Testimony	1,051,000	831,000	-220,000
Recommitment Updates	461,000	408,000	-53,000
Airfare Costs	141,000	156,000	15,000
Consultation Costs	47,000	52,000	5,000
Totals	**$4,874,000**	**$5,422,000**	**$548,000 Need**

Subcommittee Staff Recommendation. It is **recommended to adopt the May Revision.** No issues have been raised.

II. ISSUES FOR DISCUSSION

A. Item 4280--Managed Risk Medical Insurance Board (*Discussion Items*)

1. Healthy Families Program—*Baseline Program and Caseload Estimate* (issues 123 & 110)

May Revision. A total of $1.027 billion ($371.1 million General Fund, $646.3 million Federal Title XXI Funds, $2.2 million Proposition 99 Funds, and $7.7 million in reimbursements) is proposed for the HFP, excluding state administration. **This reflects a *decrease* of $19.8 million ($6.1 million General Fund) as compared to the January budget.**

The proposed adjustments reflect (1) an increase in the rates paid to participating health plans, (2) a reduction in caseload, (3) the implementation of the Medi-Cal to Healthy Families Bridget Performance Standards, and (4) the expansion of the Health-e-App. With respect to rates, a 3.2 percent increase in the average monthly rate for health, dental and vision coverage to children aged 1 through 18 years was provided by the MRMIB as of March 1, 2006. An increase of 0.2 percent was also provided for infant coverage (0 to 1 year).

The May Revision assumes a total enrollment of 867,727 children as of June 30, 2007, a decrease of 65,384 children as compared to the January budget. The May Revision caseload reflects an increase of about 11 percent over the revised current-year.

This projected enrollment level reflects a higher growth trend primarily attributable to **(1)** proposed modifications to the enrollment process; **(2)** increased funding for outreach; and **(3)** a proposed incentive plan for the Certified Application Assistance Program.

As required by the health trailer bill for implementation of the Budget Act of 2005, the May Revision includes an increase of $5.4 million ($1.9 million General Fund) for the enrollment impact in the HFP from the implementation of the Medi-Cal to HFP Bridge Performance Standards. These standards place requirements on the counties to effectively process applications, as applicable, for the enrollment of children into the program.

The May Revision also proposes an increase of $1.8 million ($1 million foundation grant funds and about $800,000 federal funds) to make the Health-e-App available to the public. Developing a publicly available web-based version of the Health-e-App will assist with enrollment and retention. The January budget had also made this assumption but did not fully address the availability of obtaining resources for it. Therefore, this funding is provided in the May Revision.

Overall Background on the HFP. The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to uninsured children (through age 18) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until *at least* the age of two. If these AIM to HFP two-year olds have families that exceed the 250 percent income level, then they would no longer be eligible to remain in the HFP.

Table: Summary of Eligibility for Healthy Families Program

Type of Enrollee	Family Income Level	Comment
AIM infants (born to AIM mothers)	200 % to 300 %	Up to 2-years only, if above 250 %. Otherwise, through age18.
Children 1 to 5 years of age	Above 133% to 250%	Children this age who are under 133% are eligible for Medi-Cal.
Children 6 years up through age 18.	101 % to 250%	Children this age who are 100% and below are eligible for Medi-Cal.
Some children enrolled in county "healthy kids" programs. (AB 495 projects)	250% to 300%	State provides federal S-CHIP funds to county projects as approved by MRMIB.

Families pay a monthly premium and copayments as applicable. The amount paid varies according to a family's income and the health plan selected. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums.

The Budget Act of 2004 and accompanying trailer bill language increased the premiums paid by higher income families effective as of July 1, 2005. Specifically, as of July 1, 2005, families with incomes between 200 percent and 250 percent of poverty will pay $12 to $15 per child per month (currently it is $4 to $9 per child). The family maximum per month will be $45 (currently it is $27 per family) for these families.

Families below 200 percent of poverty pay premiums ranging from $4 to $9 per child per month, up to a family maximum of $27 per month. This premium level has not changed.

California receives an annual federal *allotment* of Title XXI funds (federal State-Children's Health Insurance Program) for the program for which the state must provide a 35 percent General Fund match. The federal allotment slightly varies contingent upon appropriation by Congress. This is *not* a federal entitlement program.

Subcommittee Staff Recommendation. It is **recommended to approve the May Revision. No issues have been raised with these baseline adjustments to the program.**

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. **MRMIB**, Please provide a brief summary of the request, highlighting the caseload aspect.

2. Proposed Modification to New Incentive Program for CAA's (issue 124) *(See Hand Out)*

Prior Subcommittee Action (April 17th). In a prior hearing, the Subcommittee took the following actions to expand access to the HFP and Medi-Cal programs:

- Adopted trailer bill language and positions to streamline the HFP enrollment process;
- Adopted an increase of $19.7 million ($8.5 million General Fund) to implement a county-based outreach, enrollment and retention program;
- Approved an increase of $11.8 million (total funds) to provide the $50 fee and $25 fee to Certified Application Assistants (CAAs) for each successful new enrollee and redetermination; and
- *Rejected* an increase of $2.5 million ($1 million General Fund) to create a new incentive program for CAAs. Under this proposal, the Administration would have paid an incentive payment if a CAA had increased the number of their assisted applications by 20 percent over their prior quarter applications. The incentive payment would have been 40 percent of the total payments made in the qualifying quarter. (The LAO and several constituency groups also recommended rejection of this new incentive program.)

May Revision—Creates a New Incentive CAA Program. The May Revision proposes to change the Administration's January budget proposal regarding the establishment of a new incentive CAA Program. **The new proposal would do the following:**

- *Change Annual Eligibility Redetermination Payment.* This proposal would increase the amount paid to CAAs for successful "annual eligibility redeterminations" (AERs) from $25 to $50 per application. A total of about $1.1 million ($400,000 General Fund) is provided for this purpose. The purpose of this proposal is to place the AER on par with the payment made for assisting with new applications (i.e., $50).

- *Additional Incentive if Health-e-App Used.* This proposal would provide an additional $25 to CAAs for any new application or AER that is successfully completed using the Health-e-App web-based application. A total of $3 million ($1.1 million General Fund) is provided for this purpose.

- Rescinds the January budget proposal that was previously rejected by the Subcommittee.

As previously noted, the MRMIB proposes to expand the statewide availability of the **"Health-e-App", a web-based application** that is now only available through Certified Application Assistants (CAAs) and only in some counties. This expanded availability is to take place during 2006-07, as noted in the previous agenda item.

Subcommittee Staff Recommendation. It **is recommended to (1)** adopt the proposal to increase the payment made to CAAs for successful AERs from $25 to $50, and corresponding technical trailer bill language, *and* **(2)** reject the $3 million ($1.1 million General Fund) for the use of the Health-e-App.

It makes sense to provide CAAs $50 for AERs since retention and continued enrollment are now a core concern of the program, with enrollment now covering almost 800,000 children. Clearly it is most beneficial to the child to maintain enrollment and it is cost-beneficial to the program as well since the "churning" of enrollment just adds administrative costs to the program.

With respect to the Health-e-App incentive payment proposal, it appears to be premature. The Health-e-App still needs to be developed for statewide use, including various administrative adjustments, and it does require access to computers. The baseline CAA Program was just restored last year and is in the process of building up again. In addition, CAAs should already be using Health-e-App, *when applicable*, because it generally enrolls children more quickly.

Further, Health-e-App does not serve as a screening device for the more complex Medi-Cal enrollment categories such as disability-linked Medi-Cal and the 1931 (b) family Medi-Cal program. It does however serve as a useful tool for screening children for the federal poverty level programs (such as the 100 percent program and the 133 percent programs) prior to enrollment into the HFP. (Federal law states that Children's Health Insurance Programs, the Healthy Family Program in California, are to be used for those children not eligible for Medicaid and who are citizens.)

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. **MRMIB**, Please provide a brief summary of the May Revision proposal.

3. Proposed Modification to Trailer Bill Language Regarding AIM to Conform

Issue. The Assembly Subcommittee adopted a modification to the Administration's trailer bill language regarding the interactions between the Access for Infant's and Mothers Program (AIM) and the Healthy Families Program. **Specifically, Section 12695.05 (d) (3) was changed to provide an additional subscriber contribution for two months. The Assembly's language change is noted below:**

> (3) In addition to the subscriber contribution specified in this subdivision, for subscribers enrolled on or after July 1, 2007, the board may also assess an additional subscriber contribution to cover the AIM-linked infant enrolled in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 1693.70 for two months using all applicable discounts pursuant to Section 12693.43.

This language was modified because the Administration did not specify in their language how much of a premium could be collected in advance. Instead, the Administration assumed that implementing regulations would be crafted to address this issue.

Background--Prior Subcommittee Action. In the April 17th hearing, the Subcommittee adopted the Administration's proposed trailer bill language to eliminate the potential for duplicative enrollment in the Access for Infants and Mothers (AIM) Program and provided a one-time only augmentation as contained in the Governor's Budget.

Background--Governor's January Budget Proposal. The MRMIB proposed to make several changes regarding the linkage between the Access for Infants and Mothers Program (AIM) and the Healthy Families Program (HFP). **These changes require a *one-time time* only augmentation, as well as statutory changes proposed through trailer bill legislation**. First, a *one-time only* increase of $300,000 ($105,000 General Fund) was requested for the Administrative Vendor to make system changes. The purpose of this HFP system change would be to eliminate the potential for AIM-linked infants to be enrolled in either the no-cost Medi-Cal Program or private insurance, as well as in the HFP.

Once implemented the proposal is to result in *annual savings* to the state of about $951,000 ($333,000 General Funds). These savings would come from not enrolling infants into the HFP who are already enrolled in no-cost Medi-Cal or employer supported insurance. It is assumed that system changes would be effective as of July 1, 2007 (i.e., next fiscal year).

The proposal would also expedite HFP enrollment for infants born to AIM mothers by allowing MRMIB to redirect a portion of the AIM subscriber contribution to the HFP account and to apply this money towards the infant's HFP premium for a period of HFP enrollment. The Administration is proposing trailer bill legislation to amend the HFP and AIM statutes to make the above referenced changes. **Specifically, the proposed trailer bill legislation would do the following:**

- Identify AIM-linked infants who are enrolled in no-cost Medi-Cal or employer sponsored insurance at the time of registration (and therefore not eligible for the HFP);
- Enable the MRMIB to assess an additional HFP subscriber contribution as part of the AIM subscriber contribution and require that this portion of the AIM subscriber contribution be used as *pre-payment* of the HFP premium for an AIM-linked infant's initial enrollment into the HFP; and
- Provides for the transfer of the above contribution from the mother's AIM account to the child's HFP account.

According to the MRMIB, over 20 infants each month are enrolled in the HFP as AIM-linked infants ***and*** also are enrolled in no-cost Medi-Cal. As such, California and the federal governments may be paying twice for the coverage of these infants. In addition, it is unknown how many AIM-linked infants are enrolled in employer sponsored health care coverage, since the current enrollment process does not require the disclosure of this information. **Therefore, the MRMIB is recommending the Administrative Vendor system changes and trailer bill legislation to prevent dual enrollment (i.e., in the HFP and Medi-Cal or employer sponsored coverage) and to clarify the subscriber payments.**

Background on AIM and HFP Relationship. The Budget Act of 2003, and accompanying trailer bill legislation, provided for the automatic enrollment of infants into the HFP when born to AIM mothers who were enrolled in AIM on or after July 1, 2004 (i.e., AIM-linked infants). This action was proposed by the Administration because the contract costs in AIM were increasing steadily and the cost for providing health care services for the infants would be less in the HFP than in AIM. Prior to this change, AIM infants were eligible for AIM up to the age of two years.

Currently, AIM requires an enrollee to pay 1.5 percent of her household income as the family contribution towards the cost of participation in AIM. To enroll the infant born of this pregnancy in the HFP, an additional $15 premium payment is required. According to the MRMIB, the requirement for a separate HFP premium can lead to delays in enrollment of the infant. Under current law MRMIB does not have the authority to charge an AIM subscriber for care provided to her child in the HFP, which is a separate program.

Subcommittee Staff Recommendation. It is recommended to adopt the proposed language change to **conform to the Assembly**. This technical language change makes it clear

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. MRMIB, from a technical assistance perspective, please describe the proposed change.

4. County Health Initiative Interim Assistance—*One Time Funding* (issue 128) *(See Hand Out)*

Governor's May Revision. The May Revision **proposes a *one time only* amount of $22.8 million (General Fund) to be allocated by the MRMIB to County Health Initiative programs to enroll about 24,000 children in 2006-07. In addition, an increase of $251,000 (General Fund) is requested for state support to fund three limited-term positions—a Research Specialist I, Associate Accounting Analyst and an Office Technician—to administer the funds.**

In addition, trailer bill language is proposed. This is discussed below.

The MRMIB states that they anticipate a total of 18,000 children (aged 6 to 18 years) to be on waiting lists for enrollment into County Health Initiative programs during 2006-07. This is because some of the County Healthy Kids programs have had to cap their enrollments due to high program demand and limited funding. Most of the capped programs have formed "wait lists" so that as older children graduate from the program or children drop out, other children can be enrolled. The wait lists are only for children ages 6 to 18 years since funding from the First 5 Commission has been sufficient to cover all children ages 0 to 5 years that are eligible.

Most counties have reported that the cost of covering one child is from $80 to $120 per month. Most County Health Initiatives utilize health plans with existing Medi-Cal and Healthy Families Program provider networks to serve their enrollees. **Therefore, the Administration assumed a cost of about $100 per child for their cost calculation, or about $1,195 as an annual cost (12 months).**

The Administration states that the first priority for funding allocation would be to 10 counties that presently have a waiting list of about 11,000 children (See Table below). The remaining funds would be allocated across all 18 counties that have a program.

The proposed trailer bill language would do the following:

- Create the County Health Initiative Interim Assistance Program to be administered by the Managed Risk Medical Insurance Board (MRMIB);
- Make one-year grants to the Children Health Initiatives for the provision of health care for children **ages six through 18 years** who are not insured or eligible for coverage under the HFP or full-scope Medi-Cal with no share of cost;
- Designates that the **first priority** for the grants will be for Children's Health Initiatives that, as of **May 1, 2006**, had an established waiting list of children;
- Designates that the **second priority** for the grants, if any funding remains from the first priority, would be for all Children's Health Initiatives, not just those with waiting lists. The MRMIB would develop criteria for awarding such grants but would include, among others, the following:
    - Whether the program can use the grant to leverage other funds;
    - Whether the funds of the program, absent a grant, are sufficient to cover the projected number of eligible children;
    - How many children would be served as a result of the grant; and
    - Evidence that the program is adequately screening children to ensure that they are not eligible for other comprehensive public programs (i.e., Medi-Cal or the HFP).
- Require the Children Health Initiatives receiving funds to certify to the MRMIB that funds are being used for the specified purposes; and
- Enables the MRMIB to review, monitor or otherwise review the information provided by the Children Health Initiatives and may require funds to be returned.

The requested MRMIB positions would generally be used as follows:

- The Research Program Specialist I would oversee the program, coordinate with counties and review programs in the field;
- The Associate Analyst would establish and maintain the required fiscal reporting systems, analyze certified documentation received from the programs (such as financial statements, fiscal projections and related material), and assist in field reviews; and
- The Office Technician would provide clerical support.

Additional Background—County Health Initiative Programs. Presently there are **18 county-based programs** (often referred to collectively as County Health Initiative programs) that provide health care coverage to uninsured children in families with incomes below 300 percent of poverty (400 percent for one county). **These uninsured children are not eligible for full-scope, no cost Medi-Cal or the Healthy Families Program.** These existing programs cover about 85,000 children. Counties have used many funding sources to support these programs including resources from the counties themselves, local First Five Commissions, foundations, and federal funds. In addition, there are 14 other counties that are planning to implement programs.

According to a recent report (May 2006 funded by the CA Endowment), there are about **10,200 children (aged 6 to 18 years) (based on *January 2006* available data) who are on a waiting list as noted in the table below.**

Table: Children Enrolled in County Health Initiative Programs (from referenced report)

County Healthy Kids	Total Children Enrolled (0 to 18 yrs)	**Wait Listed Children** (6 to 18 years)	Estimated Total Eligible Children
Santa Clara	13,460	970	18,000
San Francisco	4,180	0	5,000
Riverside	7,080	2,370	17,000
San Mateo	5,910	0	7,150
San Bernardino	3,710	1,620	22,000
Los Angeles	42,940	3,970	70,000
San Joaquin	2,110	160	3,000
Santa Cruz	1,760	0	2,300
Kern	100	n/a	2,000
San Luis Obispo	490	90	2,200
Alameda	580	0	11,000
Santa Barbara	180	0	4,000
Tulare	0	930	6,800
Fresno	100	0	8,550
Solano	860	0	2,000
Sonoma	1,700	100	2,700
Yolo	0	0	2,350
TOTALS	**85,210**	**10,210**	**186,050**

Subcommittee Staff Recommendation. It is **recommended to approve the May Revision.** The intent of the $22.8 million (General Fund) is to provide a interim assistance to operating County Health Initiatives in the short term until resolution of the children's health initiative on the ballot in November. It is a constructive use of one-time only funding. Further, the workload for the requested positions seems justified in order to ensure the integrity of the allocations and their use for health care services.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. **MRMIB**, Please briefly describe how the program would operate, including when the first phase of grants would be provided.

B. Item 4260 Department of Health Services (*Discussion Items*)

MEDI-CAL PROGRAM ISSUES

1. Medi-Cal Baseline Estimate Package & Technical Adjustments to Prior Actions

Governor's May Revision: The entire Medi-Cal Estimate is recalculated at the May Revision. As such, the Estimate package needs to technically be adopted as a baseline **and *then*** individual issues are adjusted as needed (as discussed in the issues noted in the Agenda below).

The Medi-Cal Program local assistance expenditures for 2006-07 are estimated to be $31.410 billion ($13.768 billion General Fund), excluding special funds provided to hospitals. This reflects a *net* increase of $545.9 million (**increase of $29.7 million General Fund**) as compared to the January budget. Estimated expenditures are shown below by category.

Summary Totals of Governor's May Revision for Medi-Cal Program

Component of the Medi-Cal Program	May Revision 2006-07
Medical Care Services	$29.070 billion ($12.974 billion GF)
County Administration	$2.030 billion ($700 million GF)
Fiscal Intermediary	$310 million ($93.6 million GF)
TOTAL	$31.410 billion ($13.769 billion GF)

The average monthly caseload for 2006-07 is projected to be 6,664,700 Medi-Cal enrollees which represents a **decrease** of 142,100 people, or 2.1 percent from the January budget.

Adjustments for Prior Actions by Subcommittee. In prior hearings the Subcommittee took action to make adjustments to the Medi-Cal Program's local assistance item. These adjustments need to be technically updated to correspond to the May Revision changes for caseload and related items. **Therefore, it is recommended to make the following adjustments to the May Revision baseline budget as follows:**

- *County Administration Change*. The Subcommittee **rejected** the DHS proposal to reduce County Administration by $42.4 million ($21.2 million General Fund). The May Revision has lowered their reduction amount to be $24.3 million ($12.2 million General Fund). **Therefore, it is recommended to *revise* the Subcommittee's prior action to increase by $24.3 million ($12.2 million General Fund) to reject the Administration's proposal.**

Questions:

1. DHS, Please provide a *brief* summary of the baseline adjustments for Medi-Cal.

2. County Performance Measures

Issue and Subcommittee Staff Recommendation. Concerns have been raised regarding the ability of counties to meet statutorily required performance measures, as discussed below, in the event of not being appropriately funded for the cost of administering Medi-Cal Program eligibility processing. As noted below, the state savings over $200 million (General Fund) by the counties meeting these performance measures.

In an effort to continue discussions through the Joint Budget Conference Committee process between the Administration and the counties on the topic of funding and the efficiency of conducting Medi-Cal eligibility processing and other related important county administration functions, it is recommended to adopt the following Budget Bill Language for the Medi-Cal local assistance item:

> Provision x.
>
> It is the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal Program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in Section 14154 of the Welfare and Institutions Code.

Background—County Performance Standards. Through SB 26 (First Extra Ordinary Session), Statutes of 2003, the Legislature enacted comprehensive "county performance standards". Under these standards, counties must meet specified criteria regarding completing eligibility determinations and performing timely re-determinations. Specific work standards—including timeframes and percentages that need to be completed—are outlined in the enabling statute. **If a county does not meet these performance standards, their administrative funding may be reduced by up to two percent as determined by the Department of Health Services. Further, implementation of a corrective action plain in those counties that fail to meet one or more of the standards are required.**

The county performance standards address requirements for **(1)** Medi-Cal eligibility application processing, **(2)** Medi-Cal annual redetermination processing, and **(3)** bridging processing which is used to shift children from Medi-Cal to Healthy Families and back as appropriate due to different program eligibility standards.

As contained in the Medi-Cal Estimate for 2006-07, these ongoing county performance standards are estimated to save about $445.7 million ($222.8 million General Fund).

The DHS states that it received 4 positions (two permanent and two limited-term) for this purpose.

Background—County Cost Containment Plans. Through the Budget Act of 2004, and accompanying trailer bill language, the DHS in collaboration with the County Welfare Directors Association were directed to develop options and recommendations for modifying the budgeting and allocation methodologies for county Medi-Cal administration. Recommendations from this process were provided to the Legislature in 2005.

A principle component of the cost containment plan is the application of productivity standards in determining the number of eligibility workers needed for the Medi-Cal determination process which is based upon a county's computer consortia. **The Governor's budget reflects savings of $5.6 million ($2.8 million General Fund) for this purpose.**

Background—Medi-Cal Eligibility Determination System (MEDS) Reconciliation. Additional standards were implemented in the Budget Act of 2003, and accompanying trailer bill language to ensure that counties were appropriately reconciling their Medi-Cal eligibility files with the state's system. This included the establishment of standards regarding the processing of error "alerts", as well as submitting quarterly reconciliation files to the DHS for data verification and correcting any subsequent identified errors. **If a county fails to follow these standards, the DHS will request a Corrective Action Plan from the county. If the county fails to meet the Corrective Action Plan's benchmarks, the DHS may reduce the county administrative allocation for Medi-Cal by two percent.**

Background—Medi-Cal Eligibility Processing. Each county is responsible for implementing Medi-Cal eligibility and for interpreting state guidance on policies and procedures. Counties determine eligibility for Medi-Cal under a set of complex rules that require staff to collect and verify a variety of information. **In fact the DHS provides counties with a 900-plus page state Medi-Cal Eligibility Procedures Manual that is updated on a constant basis through state issued "All County Letters". There are more than 150 aid codes, and dozens of state Medi-Cal related forms.**

Counties are provided with an annual allocation from the state to conduct Medi-Cal Program eligibility processing activities for the state (federal law requires that a governmental entity complete all Medicaid (Medi-Cal) applications.) The allocation is contained within the annual Medi-Cal Estimate Package provided to the Legislature as part of the annual budget deliberations. The budget proposes expenditures of about $1.3 billion (total funds) for county administration of the Medi-Cal Program.

County-Based Constituency Organization's Request. The Subcommittee is in receipt of a letter that **(1)** requests denial of the Administration's proposal, and **(2)** adoption of placeholder trailer bill language to fund the **actual** cost to counties to administer both human services and Medi-Cal beginning in 2007-08.

Among other things, the letter notes that counties provide important services to their local constituents while serving as an arm of the state. Further, County Counsels' Association has opined that not funding increases to counties for costs to administer programs on behalf of the state amounts to a cost shift triggering the mandate reimbursement provisions of Proposition 1A.

The County Welfare Directors Association (CWDA) appropriately notes the inconsistency of the DHS by proposing to cut funding for county Medi-Cal operations while leaving all statutory performance requirements intact.

3. Conlan v. Shewry –Request for Budget Bill Language

Issue. The Subcommittee is in receipt of a letter requesting that Budget Bill Language be added to enable counties to establish specific timeframes for assessing the (1) impact on county Medi-Cal eligibility processing and (2) allocating funds to counties for these new activities.

The Conlan v. Shewry settlement will require the state to revise policies and procedures for allowing Medi-Cal beneficiaries to claim costs for health care received during a three-month period before eligibility. Initially, the new rules must be applied retroactively to clients granted Medi-Cal since 1997, and then to all new clients. Counties will be required to research cases and provide information to assist in determining retrospective funding amounts. Prospectively, the application process for Medi-Cal eligibility will be lengthened after these new rules are implemented.

It is unclear at this time the number of cases involved or the amount of time each case will require. **However, the court ordered that the DHS must have a reimbursement process fully implemented by *October 2006*. Therefore, the CWDA is seeking Budget Bill Language which will enable the DOF to transfer funding to the counties for Medi-Cal eligibility assistance. This language is as follows:**

> Item 4260-101-0001
> Provision x. Not later than October 1, 2006, the Director of Finance shall authorize the transfer of amounts from Schedule (3) of this item to Schedule (1) of this item in order to fund increased costs to county Medi-Cal eligibility programs associated with compliance in the Conlan v. Shewry court decision.

Background—Conlan v. Shewry. This lawsuit has a long history resulting in the issuance of several court decisions. The first decision was issued in 2002 and directed the DHS to adopt and implement procedures to ensure that Medi-Cal recipients entitled to reimbursement for covered services obtained during the "retroactive period" (defined as the three-month period prior to application for Medi-Cal) are promptly reimbursed.

Now, as ordered in May 2006 the court ordered that the DHS must have a reimbursement process fully implemented by October 2006. Failure to meet this deadline would result in contempt sanctions by the court against the DHS.

Subcommittee Staff Recommendation. It is recommended to adopt the proposed Budget Bill Language as referenced above.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief description of the Conlan v. Shewry decision. Is it likely to have an affect on counties?

4. Proposed Adjustment to Treatment Authorization Requests--Podiatry

Issue. The Subcommittee is in receipt of a letter from constituency groups requesting trailer bill language that would enable a doctor of podiatric medicine, within their scope of practice, to provide treatment under the Medi-Cal Program for certain procedures without having to submit a "treatment authorization request" (TAR).

In discussions with the DHS, from a technical assistance basis only, it appears that crafting trailer bill language would facilitate the ability of the DHS to indeed, not require TARs for these procedures. **Specifically, *no* TAR would be required for billing codes related to trauma, infection management, pain control, would management, diabetic foot care, and limb salvage.** Only a small number of codes would be affected by this change. The procedures specified are urgent conditions that are medically required, not those that could be over utilized.

Medi-Cal patients who benefit from this change are medically compromised diabetics, dialysis patients, peripheral vascular disease patients, and patients with trauma (limb damage).

Additional Background Information--TARs. Medi-Cal requires providers to obtain prior authorization for specific medical procedures and services before Medi-Cal reimbursement can be approved. To file a TAR, providers must fill out one of several types of TAR forms and forward the TAR, usually by mail but also electronic, to the appropriate DHS TAR office (six Medi-Cal Field Offices and two Pharmacy offices). The DHS then processes the TAR to either (1) approve, (2) modify—such as quantity of service, (3) defer—return to provide for more information, or (4) deny the request.

Generally, the purpose of any prior authorization system is to (1) assist in reviewing medical necessity, (2) assist in cost control, and (3) assist in fraud detection.

Subcommittee Staff Recommendation. It is **recommended to (1)** adopt **"placeholder"** trailer bill language, in order to obtain technical assistance from the DHS, ***and* (2)** increase by $200,000 ($100,000 General Fund) since the DHS believes that nominal costs will be incurred.

Questions. The Subcommittee has requested the DHS to provide technical assistance by responding to the following questions.

1. **DHS**, from a technical assistance basis, please comment on the proposal.

5. Medi-Cal Managed Care Plan Payment Adjustments—*Two Issues* (issue 130)

Governor's May Revision. The May Revision proposes **two adjustments** to the rates paid to health plans participating in the Medi-Cal Managed Care Program. The Medi-Cal Managed Care Program serves over 3.2 million enrollees (almost half of all enrollees) using three models—Two Plan Counties, County Organized Healthcare Systems (COHS) and Geographic Managed Care.

First, the 5 percent rate reduction required by AB 1762, Statutes of 2003, sunsets as of December 31, 2006. As such, the May Revision reflects this sunset date and provides **an increase of $65.4 million ($32.7 million General Fund) to be effective as of January 1, 2007 (half year funding).** The adjustments are *not* affected by a plans' Medi-Cal Program contract date. **The adjustments for this are shown below.**

Table: Restoration of 5 Percent as of January 1, 2007

Managed Care Model	Total Dollar Amount
Two-Plan Model	$45,000,000
County Organized Healthcare Systems	$13,500,000
Geographic Managed Care (Sacramento and San Diego)	$6,600,000
TOTAL Medi-Cal Managed Care	**$65.1 million**
Pilot Programs:	
PACE	$20,000
SCAN	$45,000
AIDS Healthcare Foundation	$200,000
Kaiser Prepaid Health Plan	$50,000
TOTAL Pilot Programs	**$315,000**

Second, **an increase of $61.2 million ($30.6 million General Fund) is provided based upon a DHS financial review of the 22 Managed Care plans.** This financial review process was discussed in the Subcommittee on May 8th, and is referenced below in the background section. But generally, the purpose of the DHS financial review was threefold:

- Determine which health plans exhibit evidence of a declining "tangible net equity" (TNE) or depleting financial reserves to a level that would render the health plan non-compliant with state regulations prior to 2007-08 (i.e., below 200 percent of TNE);
- Ascertain if funding for a rate increase is justified; and
- Establish the amount of funding to be requested in the May Revision for 2006-07.

Of the 22 Managed Care Plans reviewed, 10 plans warranted DHS criterion for consideration of a rate increase to maintain financial compliance. As such, the DHS did a more comprehensive "secondary" financial review. After this secondary review, 6 plans were included in the May Revision for a rate increase.

The DHS made recommendations as noted below. The total amount of $78.050 million ($39.025 million General Fund) should have been reflected in the May Revision. **However, a technical correction to the May Revision is needed to appropriately reflect the full amount. *Specifically*, an increase of $16.875 million ($8.438 million General Fund) above the May Revision amount of $61.2 million (total funds) is needed to reflect the full amount identified by the DHS. The total amount for each plan is shown below with their "correction" shown where applicable.**

- Central Coast Alliance for Health (COHS) $17.370 million (correction of $9.7 million)
- Health Plan of San Mateo (COHS) $7.670million
- Partnership Health Plan (COHS) $25.3 million
- Santa Barbara Health Authority (COHS) $11.160 million (correction of $6.3 million)
- Contra Costa Health Plan (Two-Plan Model) $2.860 million (correction of $875,000)
- Community Health Group (Geographic) $13.690 million

It should also be noted that the Administration has stated that this rate adjustment for 2006-07 is to be viewed as a "stop-gap" measure and that additional changes to rates and the methodology used to development them will be evolving once the Mercer Report and subsequent analysis is completed.

Background—Department of Health Services Financial Review of Medi-Cal Managed Care Plans. The DHS did an extensive review of the financial condition of each contractor in *all* of the Medi-Cal Managed Care Programs (i.e., Two-Plan Model, County Organized Healthcare Systems (COHS), and Geographic Managed Care (GMC)).

Key data that the DHS is reviewed regarding each of the plans included the following:
(1) *Net income.* The earnings of the company as calculated as revenues minus expenses.

(2) *Cash Flow Position.* The DHS review will analyze the liquidity of the health plan.

(3) *Tangible Net Equity.* This is a measure of the plan's financial reserves and provides a margin of financial safety if it is necessary for a plan to sustain losses over some period.

(4) *Medical Loss Ratio.* This provides the percentage of revenues devoted to providing medical care plan enrollees.

(5) *Administrative Expense Ratio.* These are costs necessarily incurred to operate a health plan.

(6) *Profit Margin.* This value shows a plan's profits or losses as a percentage and is calculated as net income divided by total revenue.

(7) *Medi-Cal Enrollment as a Percent of Total Enrollments.* This is an important factor given as it provides the ability or inability for a plan to subsidize across lines of business.

(8) Data from Most Recent Audited Financial Statements. These statements are reviewed by auditors who then consider if the health plan is a viable and ongoing entity.

Background—Quality Improvement Assessment Fee Rate Increase. Medi-Cal Managed Care Plans, except for COHS', are also participating in the "Quality Improvement Assessment" fee effective as of July 1, 2005. This arrangement enables plans to pay the state a fee (6 percent) that

is then matched with federal funds to provide a rate increase. The state was able to offset General Fund expenditures from this arrangement as well. This arrangement enabled plans to receive about a 3 percent increase on average. This program is scheduled to end by 2009 due to recent changes in federal law.

Background—Mercer Managed Care Rate Methodology Study. The DHS has contracted with Mercer to conduct an analyses regarding Medi-Cal Managed Care Program rates. According to the DHS, this analysis should be completed by **August 2006**. The objectives of this study were discussed in the Subcommittee's May 8th agenda.

Subcommittee Staff Recommendation. It is recommended **to increase the May Revision by $16.875 million ($8.438 million General Fund) to correct the calculation.**

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS,** Please provide a brief summary of the proposal and how the rate adjustments were determined.

6. Expansion of Disease Management Pilot Project to Include Second Contract (issue 142)

Governor's May Revision. The May Revision **proposes an increase of $2 million ($1 million General Fund) to expand the Disease Management Project to include an *additional* pilot to be designed to serve people with HIV/AIDS.** The DHS states that this project would be a separate (stand-alone) contract and would begin January 1, 2007. The DHS notes that a separate project would be done since HIV/AIDS presents different medical issues than those in other disease management programs.

The DHS contends that it can indeed have this project operational because they have learned from the development of the prior contract (first project).

Prior Subcommittee Action. As noted earlier, the Subcommittee adopted an LAO recommendation to reduce by $1 million ($500,000 General Fund) to reflect a delay in the implementation of the *first contract* for Disease Management that addresses other conditions, including Advanced Atherosclerotic Disease Syndrome, Asthma, Coronary Artery Disease, Diabetes and Chronic Obstructive Pulmonary Disease. **(This action is separate and apart from this May Revision request, since it pertained to the *first* contract.)**

Additional Background Information. The Disease Management Pilot Project was approved by the Legislature through the Budget Act of 2003. The purpose of this three-year pilot project is to test the efficacy of providing a disease management benefit to Medi-Cal enrollees. This is to include, but not be limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, providing patient education, monitoring, and strategies for healthy lifestyle changes.

Legislative Analyst's Office Recommendation. The LAO recommends rejecting the May Revision proposal to add a second contract for HIV/AIDS for savings of $2 million ($1 million General Fund). They contend that other existing projects are already taking significant actions to improve care, control costs, and achieve better health outcomes for individuals with HIV/AIDS.

Subcommittee Staff Recommendation. It is **recommended to give the DHS a *second chance* on a Disease Management project and to approve this second concept on HIV/AIDS as contained in the May Revision. (The Subcommittee's prior action would remain.)**

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief summary of the proposal.

7. Trailer Bill Language Proposed for Federal Deficit Reduction Act (issue 143) (See Hand Out)

Governor's May Revision. The May Revision **proposes trailer bill language to implement certain provisions of the federal Deficit Reduction Act (DRA) of 2005, as well as related Budget Bill Language that would provide for a transfer of funds to County Social Services Departments to conduct additional activities.**

Background on the Federal DRA and What it Could Mean for California. The DRA requires all U.S. citizens and nationals who apply for Medicaid (Medi-Cal) to provide **evidence of citizenship or national status as a condition of eligibility. The DHS states that the DRA does *not* apply to or affect people who are applying for Medi-Cal who are legal immigrants.**

This new federal requirement is effective July 1, 2006 and would be required when people apply for Medi-Cal benefits or, for current beneficiaries, at re-determination of eligibility. There are no exceptions to this requirement.

These new federal requirements require both state statutory changes, as well as an amendment to the State's Medi-Cal Plan. **By September 30, 2006, the DHS must submit a State Plan Amendment (SPA) to implement this change which becomes effective July 1, 2006 (federal law contains this date).** (Generally, the federal CMS requires that states can only go back one-quarter for changes to Medicaid programs.)

Implementation of these DRA requirements is a condition of the state *receiving* federal funds. The DHS states that failure by California to act puts $15 billion in annual federal funds at risk. Federal funds (Title XIX funds) expended by other state departments, counties and schools would also be at risk.

According to the DHS, the *primary* forms of documentation acceptable would be either a passport (by its self), or a birth presented together with a document that confirms identity, such as a driver's license with a photograph.

The federal CMS is working on directions to the states, which could provide flexibility to states to accept *alternative forms* of documentation, including electronic verification of birth certificates and affidavits for children to prove their identify. They are also working to provide direction that could allow states to rely upon the verification of other programs, such as SSI and foster care as proof that this requirement has been met. In addition, they are working to provide applicants and beneficiaries a "reasonable opportunity period" which would allow people to be eligible without presenting the documentation and then provide it within the first two months of eligibility. The DHS notes that discussions with the federal CMS indicate that states should have some flexibility in implementation.

Eligible people could lose their Medi-Cal coverage because they do not have a birth certificate, passport, or other acceptable alternative documentation available during the process used to apply or reapply for Medi-Cal coverage. Once a person has proven citizenship

at either their time of application or determination, they will not have to meet this requirement again.

The federal CMS is also required to conduct outreach to applicants and beneficiaries as part of the implementation of this program. The DHS states that they are also looking at various outreach alternatives including providing routine notices to beneficiaries about this requirement, working closely with County Social Services Departments and Health Departments, as well as community-based organizations

Summary of the Proposed Trailer Bill Language & Budget Bill Language. The proposed trailer bill would require the DHS to implement the federal requirement using additional sources of documentation, to the extent allowable under federal law. Additional sources of documentation may include, but are not limited to, an electronic verification of birth certificate data for people born in California.

The DHS is requesting Budget Bill Language to provide for the transfer of funds between Medi-Cal programs if higher county administration costs materialize since the fiscal impact of this new requirement is unclear and undetermined at this time. **The Administration's proposed Budget Bill Language is as follows (for Item 4260-101-0001):**

> "Nothwithstanding any other provision of law and Section 26.00 of this act, the Department of Finance may authorize transfer of expenditure authority from Schedule (3) of this Item to Schedule (1) of this Item for the purposes of implementing changes required by the federal Deficit Reduction Act of 2005. The Director of Finance shall notify the Legislature within 15 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code.

The DHS notes that their proposed Budget Bill Language would allow necessary funds to be used for outreach as well; *however*, the language does not specifically state this fact.

Background—Current State Policy and Procedure. Currently in Medi-Cal, U.S. citizens and nationals are required to provide a Social Security Number (SSN) as a condition of eligibility for Medi-Cal. **Each individual's SSN is validated against the data files at the Social Security Administration for accuracy and authenticity.** Individuals who are unable to provide a valid SSN are provided limited scope services. Non-citizens applying as legal immigrants for full-scope Medi-Cal must provide documentation of their immigration status. **The DHS checks computerized federal records to verify their status.**

Medi-Cal has existing proof of identify requirements. In most cases, eligibility workers obtain identification from the "head" of household. Many Medi-Cal applicants are not currently required to provide verification of identify (like a photo ID) such as persons in institutions where contact is made with the facility to verify presence in the institution, and persons not acting on their own behalf (like infants and children).

Verification of identify for the head of household can be met by providing a driver's license or identification card issued by the Department of Motor Vehicles or any other document (preferably

with a photo) which appears to be valid and establishes identify (school identification card, Social Security card, marriage record, divorcee decree, passport, birth certificate, work badge or an adoption record, etc.)

Constituency Concerns. The Subcommittee is in receipt of **numerous letters** expressing significant concerns regarding the federal DRA. There are many issues which reflect the need to have further continued discussions in order to clarify what the most constructive approaches would be for proceeding**. Some key suggestions for discussion and consideration are as follows:**

- **Use electronic data matching for verification purposes to the extent allowable by federal law.** For example, the DHS could crosscheck eligibility in other programs that require proof of citizenship.
- **Allow a parental affidavit for children of citizen parents.** This is a commonly accepted proxy for citizenship and should be adopted to ensure that eligible children do not lose coverage.
- **Allow proof of a request for a birth certificate or citizenship papers to remain enrolled in full-scope Medi-Cal.** CA cannot require another state to respond to a request for a birth certificate, or proof of citizenship in any given time frame. Some states may take weeks or months to process a request. The onslaught of requests as a result will make delays worse. It does not make sense that a Medi-Cal enrollee would be disenrolled for the failings of a state to provide citizenship documentation in a timely manner.
- **Grant as much time as is federally allowable for Medi-Cal enrollees to obtain proof of citizenship before they are disenrolled (a grace period).** Continuity of care is very important for Medi-Cal patients. The DHS should implement the maximum federally allowable grace period.
- **Implementation should include outreach and education to patients, providers, county social services offices, community organizations and others.**
- **Exceptions in extreme circumstances.** There may be some circumstances in which a Medi-Cal enrollee is not able to obtain documentation of their citizenship status (such as a patient with dementia for example.).
- **Work with other states to help facilitate document sharing**.
- **Potential to Impact Emergency Departments and Community Clinic Systems.** To the extent that people who have been disenrolled in Medi-Cal as a result of this new law, many of them will likely show up in emergency departments and community clinic systems seeking assistance, with no insurance coverage.

Subcommittee Staff Recommendation. It is recommended to **adopt "placeholder" trailer bill language** in order to more comprehensively discuss issues with constituency groups and the Administration. This is a **very complex** issue that has very significant consequences if not done well. **In addition, it is recommended to modify the Budget Bill Language as follows:**

> "Nothwithstanding any other provision of law and Section 26.00 of this act, the Department of Finance may authorize transfer of expenditure authority from Schedule (3) of this Item to Schedule (1) of this Item for the purposes of implementing changes required

by the federal Deficit Reduction Act of 2005, which will include, but not be limited to, providing assistance to individuals in meeting these verification rules and for county eligibility activities. It is the intent of the Legislature for transfers to be provided on a timely basis in order to ensure the health and safety of Californians. The Director of Finance shall notify the Legislature within 15 days of authorizing such a transfer unless prior notification of the transfer has been included in the Medi-Cal estimates submitted pursuant to Section 14100.5 of the Welfare and Institutions Code.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief overview of the DRA provisions referenced, and a summary of the proposed trailer bill language and Budget Bill Language.

8. Request to Fund Pharmacy Study Due to Federal DRA Changes

Issue. The Subcommittee is in receipt of a request from several organizations involved in the pharmacy industry. **Specifically they are seeking an increase of $600,000 ($300,000 General Fund) to the Medi-Cal Program in order for the DHS to use a consultant to conduct a study of Medi-Cal pharmacy reimbursement.** This issue has been raised to the forefront due to changes contained in the federal Deficit Reduction Act (DRA) that affect "generic" drugs.

The Medi-Cal Program does ***not*** have to make any changes to its pharmacy reimbursement formula in order to implement these federal DRA changes**. However it is unknown at this time what the fiscal affect is going to be on the Pharmacists participating in the Medi-Cal Program**, **other than it is likely their overall reimbursement for generic drugs will be lower due to the federal reductions.** As such, **a study is requested** in order to obtain better data as to what is occurring in the field. Further, the last study completed in this area was published in June 2002 and used data from 1999-2000.

Existing State Statute Provides Flexibility Regarding Reimbursement for Generic Drugs.
Currently existing state statute sets generic drug reimbursement at the "lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit (federal UPL) or the maximum allowable ingredient cost (MAIC). Therefore, no state statutory changes are needed to implement the federal DRA changes as discussed below.

Summary of Federal DRA Changes to Generic Drug Reimbursement in Medicaid. Among other things, **the federal DRA changed the formula and conditions on when the "federal upper payment limit (federal UPL)" is set. The new requirements take effect January 1, 2007, and require the federal CMS to use 250 percent of the "average manufacturers price" (AMP) of a drug.**

The AMP is the price reported to the federal CMS by drug manufacturers and is intended to reflect the *net* (i.e., *after* discount) price paid by retail pharmacies. It is generally believed that the AMP is significantly lower than the "wholesaler acquisition cost" (WAC) which is presently used for multiplesource (generics) drugs.

State Medicaid programs (Medi-Cal) are required to implement the federal UPL by the federal CMS or risk the loss of federal financial participation (federal match) for drugs that exceed the limit. States are typically given 30-days from the date on the federal CMS letter of notification to implement new prices (this happens fairly regularly).

The DRA also lowered the number of therapeutically equivalent drugs needed to compute a federal UPL from three to only two. This change means that a federal UPL can be implemented much sooner. Currently the first generic drug on the market has a 6-month window before the second generic drug is allowed to be marketed. **This change from two therapeutically equivalent drugs now means that the federal CMS can immediately establish a federal UPL upon the introduction of the first generic drug on the market.**

Additional Background—Federal Upper Payment Limit. In 1987, federal regulations limited the amount which Medicaid (Medi-Cal) could reimburse for drugs with available **generic drugs** under the Federal Upper Payment Limit (FUPL) Program. The limits were intended to assure that the Medicaid Program acts as a prudent buyer of drugs. **The concept of the FUPL Program is to achieve savings by taking advantage of the current market prices.**

Since this time other changes have been made. **However, the bottom line is that state Medicaid programs (Medi-Cal) are required to implement the federal upper limit sent to them by the federal CMS or risk the loss of federal financial participation (federal match).**

Subcommittee Staff Recommendation. It is recommended **to increase by $600,000 ($300,000 General Fund) to fund a study regarding Pharmacist reimbursement in order to have more accurate information regarding drug ingredient costs and dispensing fee needs.** Based on technical assistance provided by the DHS, it would take about $600,000 ($300,000) to fund the study and an existing contract could be amended to complete the study in a timely manner (such as in Fall/Winter 2006) which is desired due to the federal date of January 1, 2007. **In addition, it is recommended to adopt the following Budget Bill Language (BBL)**:

> Item 4260-101-0001
>
> Provision x. Of the amount appropriated in this Item, up to $600,000 can be used to conduct a study of the pharmacy reimbursement rates and fees provided under the Medi-Cal Program, including the cost of providing prescription drugs and services. This study shall take into account the revised payments for Medicaid drug ingredient costs mandated by the 2005 federal Deficit Reduction Act. Due to the January 1, 2007 timeline for changes as contained in the federal law, it is the intent of the Legislature for this study to be conducted in an expedited manner to the extent feasible for a quality work product. The department shall provide the results of the study to the Legislature by December 1, 2006.

Questions. The Subcommittee has requested the DHS to provide technical assistance to respond to the following questions.

1. **DHS,** Please briefly explain the key federal DRA changes and how they may affect the Medi-Cal Program. Would a study be useful to complete to assist with implementation?

9. Budget Bill Language for Potential Federal Grant—"Money Follows the Person" (issue 133)

Governor's May Revision. As discussed below, the federal Deficit Reduction Act (DRA) has made a five-year grant available to states on a competitive basis. *Generally*, the grant would provide enhanced federal funding to allow individuals in institutions to move into community settings to receive the same amount of funding that was being provided for the care in the institution instead for home and community-based services.

Due to the timing of knowing if or when California may receive a grant award, the DHS is seeking the following Budget Bill Language (BBL) (for Item 4260-101-0001 Medi-Cal Local Assistance):

> "If a federal grant provides 75 percent federal financial participation to allow individuals in nursing homes to voluntarily move into a community setting and still receive the same amount of funding for services is awarded to the Department of Health Services during the 2006-07 fiscal year, then notwithstanding any other provision of law the department may count expenditures from the appropriation made to this item as state matching funds for that grant."

This BBL would enable the DHS to use existing General Fund support to match the new federal grant on a short-term basis. Since the Medi-Cal estimate pays for nursing home care, it makes sense to use the General Fund for this purpose (i.e., match at the enhanced 75 percent rate). No General Fund cost would result and savings will not be known until a program is up and running (probably late Winter/early Spring 2007). This BBL will enable the DHS to proceed with the development of a program. Further, the DHS will update the Medi-Cal estimate in January 2007 with the release of the Governor's proposed budget. Then information will be readily available.

Background—Summary of "Money Follows the Person" Demonstration Grant Program. The federal DRA authorizes this grant program that will provide states with an enhanced federal fund match for services for up to 12 months for individuals who move from an inpatient setting to a qualified community residence, beginning in January 2007. For California, the enhanced federal fund match would be 75 percent (versus 50 percent) for the services that are provided under this MFTP Grant. The intended outcome of this demonstration program is to increase the use of home and community-based care instead of institutional care by providing individuals with select services necessary to transition and keep them in their home or community.

The demonstration covers a 5-year period and the amount of the available grant awards for states start at $250 million in the first year (2007) and increase in $50 million increments each year and up to $450 million the fifth year (2011). It is anticipated that the federal CMS will release Request for Proposals to states by late summer so that projects can begin by January 2007. California will not know whether it has been awarded a grant until Fall/Winter 2006.

Subcommittee Staff Recommendation. It is **recommended to approve the Budget Bill Language** as proposed in the May Revision.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS**, Please provide a brief summary of the proposal.

10. Medi-Cal Reimbursement Adjustment for Non-Emergency Transportation

Issue. In a prior Subcommittee hearing, concerns were expressed regarding the Medi-Cal reimbursement rate paid to non-emergency medical transportation. Providers contend that non-emergency medical transportation is in jeopardy and may become unavailable in many parts of California unless relief is provided due to increased gasoline prices and maintenance. The last rate adjustment for these services was in 2000 and according to the providers, gasoline prices have increased about 120 percent since this time.

Non-emergency medical services are primarily provided to dialysis patients and who are reliant on this mode of transportation to receive their treatment at specialty clinics or hospitals. The providers note that they are more "fuel dependent" than other types of Medi-Cal services or other businesses in general. Due to the nature of the treatment, vans must get patients to the clinics on time in order for them to receive full and appropriate treatment.

Non-emergency medical transportation is covered *only* when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Transport is not covered if the care to be obtained is not a Medi-Cal benefit.

Subcommittee Staff Recommendation. It is recommended to provide **an 8 percent rate** increase for non-emergency medical providers **for an increase of $4.855 million ($2.502 million General Fund), effective as of August 1, 2006.**

According to data provided on a technical assistance basis by the DHS at the Subcommittee's request, most of the payments for non-emergency transportation go to wheelchair and litter vans for medically required transportation. The second highest non-emergency medical transportation cost is provided by ambulances. **This proposed rate adjustment would cover all providers of non-emergency transportation.**

11. Adjustments to Certain Durable Medical Equipment Items in Medi-Cal

Issue. There were a series of actions taken in the Budget Act of 2003 regarding Medi-Cal Program reimbursement rates paid to providers of various durable medical equipment products. At the time these reductions were being made, it was unknown what the affect would be to access of care if providers were not being fairly and appropriately reimbursed for their products. Further, other technical changes have occurred that need to be address to allow for a more effective program.

Concerns have been raised regarding the following issues in this area.

- *Catalogue Pricing for Custom Wheelchair Equipment.* In 2004, Medi-Cal changed its policy to require the submission of a current (then 2003 information) manufacturer catalogue page for custom wheelchair equipment. Two concerns have resulted from this change. First 2004 and

2005 catalogues have changed equipment descriptions and prices. Second, most providers access catalogue information via the internet and web based copies are not accepted by Medi-Cal as valid copies.

Based on technical assistance information obtained from the DHS, if the restriction on using the 2003 catalog pricing and related restriction were removed, it would cost about $450,000 ($225,000 General Fund). The provider would simply use the current manufacturer catalogs. Trailer bill language would also be needed for this change.

- *Custom Rehabilitation Equipment Reimbursement.* Medi-Cal changed its policy for custom wheelchair equipment and accessories that were billed on a "by report" basis using a "lesser of" approach and a sliding scale based upon a percentage of the manufacturer's suggested retail price (MSRP). Providers state that it takes additional paperwork and has dramatically increased resources required to process claims under this confusing method of payment. **If existing statute is changed, a more straightforward methodology of using a price of 85 percent of MSRP could be used. Based on technical assistance obtained from the DHS, an increase of $121,000 ($60,500 General Fund) would be needed with this change.**

- ***Oxygen Pricing.*** Medi-Cal reimbursements under different billing codes for stationary oxygen tank systems than for portable oxygen that is used and refilled on a monthly basis. Medi-Cal reimburses providers solely for the equipment and not for delivery, service or maintenance of equipment. Providers contend that it is generally recognized that the current allowable reimbursement for a portable tank delivered to the patient's home is extremely low. **Existing state statute could be changed to use consistent codes for these services and ensure that pricing stays below 80 percent of Medicare payment. Based on technical assistance obtained from the DHS, an increase of $3.9 million ($1.9 million General Fund) would be needed to make this change.**

Subcommittee Staff Recommendation. It is recommended **to increase by $4.471 million ($2.2 million General Fund) and to adopt *placeholde*r trailer bill language to effectuate the changes as noted above.**

Questions. The Subcommittee has requested the DHS to provide technical assistance by responding to the following questions.

1. DHS, From a technical assistance basis do these changes make sense to implement?

12. Proposal to Reduce the Adult Day Health Care Program—*Two Issues*

Governor's May Revision. First, the May Revision **assumes several adjustments. Each of these is discussed below.**

First, the May Revision **continues a moratorium** on the certification of new Adult Day Health Care facilities (ADHCs) that was established in 2004. The May Revision saves about $12 million ($6 million General Fund).

***Second*, that the Medi-Cal Program will achieve $19 million ($9.5 million General Fund) in savings from three changes to the delivery of ADHCs.** These proposed savings estimates reflect only four months of implementation in 2006-07 (implementation of March 2007). **These changes are as follows:**

- Review treatment authorization requests on-site (savings of $353,928 General Fund);
- Tighten the eligibility for services (savings of $1 million General Fund); and
- Unbundling the current single reimbursement rate for ADHCs to establish separate rates for some services ($8 million General Fund).

Once fully implemented, annual savings are estimated to be $116 million ($58 million General Fund).

Third, the DHS is seeking an increase of $481,000 (total funds) to hire 4 new positions—Nurse Evaluators- to implement changes to the ADHC model.

Background on ADHCs. Adult Day Health Care is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals, transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are at risk for being placed in a nursing home. ADHC has been a successful model for elderly individuals for they can obtain many services in one location. For these individuals, particularly those with mobility challenges, going to one place for health care results in better compliance with therapy, medication, nutrition, and exercise regimens. Under Medi-Cal, individuals can participate in ADHC from one to five days per week, but usually averages about three days a week.

The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money. Further, there are about 300 ADHC facilities in the state that are certified in the Medi-Cal Program.

Background on Rates. Currently, Medi-Cal reimburses an ADHC at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required). This rate includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A. This rate structure was the outcome of a legal settlement agreement. The list of required services includes, among others, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.

Legislative Analyst's Office Recommendation. The LAO recommends rejecting the Administration's unbundling proposal because they believe the savings level identified by the Administration is overstated. **Therefore, they recommend an increase of $16.2 million ($8.1 million General Fund) to backfill for this amount.** Specifically, they note that SB 1755 (Chesbro), the measure that has been identified for modification to the ADHC model does not yet contain any proposals for unbundling

Subcommittee Staff Recommendation. It is recommended to (1) continue the existing moratorium and to make a minor technical change to existing statute to clarify the moratorium, and **(2)** reject the proposals to obtain the $19 million ($9.5 million General Fund), including the requested DHS positions. As noted by the LAO, a policy bill is moving on these issues and it is going to take several months before all of the complexities of the issues can be resolved. It should be noted that both the DHS as well as ADHC provider organizations are working collaboratively to modify the existing model. **Therefore it is recommended to (1)** increase by $19 million ($9.5 million General Fund) the local assistance item to restore the proposed reduction, **(2)** decrease by $481,000 (total funds) to reject the four positions, and **(3)** adopt trailer bill language to reflect a minor technical change in the moratorium language.

Questions.

1. DHS, Please provide a summary of the proposal.

13. Administration's "Right-Sizing" Licensing & Certification Fee Changes (issue 103) *(See Hand Outs)*

Governor's May Revision (See Hand Outs). The May **Revision proposes substantial changes to the rates paid by all providers**—hospitals, nursing facilities, primary care clinics, Intermediate Care Facilities for the Developmentally Disabled-Nursing and Habilitative, psychology clinics, hospice, Adult Day Health, Specialty Care clinics, and others—for licensing and certification purposes. **The proposal, referred to as "right-sizing" of rates encompasses *several changes* as they pertain to the rates paid by these providers. The *key* changes are outlined below.**

- *Licensing and Certification Workload Needs ($18 million).* The "right-sizing" proposal adjusts fees for the additional 141 positions identified to address deficiencies in the level of staff needed to conduct licensing and certification surveys and inspections. As adopted in a prior Subcommittee hearing, and for which the Assembly has conformed, the cost for these new positions, along with $3.9 million in various contracts and $1.2 million for data operations, is $18 million in the budget year. The need for these adjustments in order to ensure the health and safety of patients has not been in debate. This proposal was contained in the January budget.
- *Shifts the Payment of Fingerprint Clearances ($2 million).* The May Revision proposes to correct for a federal **Office of Inspector General audit whereby California was found to be in conflict with federal law regarding the payment of fees to be placed onto nurse's aide registries for fingerprinting clearances.** (Specifically we cannot impose any charges, including fees paid by "certified hemodialysis technicians" and "certified nursing assistants" (CNAs))**.** Since these individuals cannot pay the fees due to federal law, the Administration proposes to include this cost into the "right-sizing" fee adjustments.
- *Changes in the Calculation of the Fees.* The proposal makes several adjustments to how the fees are calculated. Specifically, it (1) eliminates "fixed fees" that are contained in statute, (2) shifts some facilities from a "per facility" amount to a "per bed fee", and (3) requires public facilities, except for State-Operated to now pay fees. **These changes are intended to mitigate the subsidizing of some facilities (such as nursing homes and some hospitals) for other facilities (such as primary care clinics, psychology clinics and others) who have had their licensing fees set in statute and therefore, have not been appropriately paying their share of the cost for licensing surveys.** Further, some facilities that are charged licensing fees on a per facility basis are being shifted to a "per bed" basis (such as Intermediate Care Facilities for Developmentally Disabled-Nursing).
- *Increases by $4.6 million (General Fund) to Cover State Facilities and "Certified-Only" Facilities.* The May Revision proposes to increase by $4.6 million (General Fund) to **(1)** continue funding licensing activities associated with State-Operated facilities, such as State Hospitals and Developmental Centers, and **(2)** continue to provide the state match for federally certified-only facilities which are exempt from state licensure (This is $849,000 of the total amount.). This adjustment needs to be done but was not accounted for in the January budget because the "right-sizing" proposal had not been fully developed to know the amounts. (It should be noted that State-Operated facilities account for a total of $4.4 million (General Fund), including the $652,000 that was provided in the January budget.)

- *Trailer Bill Legislation (See Hand Out).* The Administration is proposing completely revised trailer bill language to implement their "right-sizing" proposal. **Key aspects of this language are: (1)** Requires the Legislature to set annual licensing and certification fees; **(2)** Eliminates all fees statutorily fixed in statute for licensing and certification activities since the Legislature will establish the fees; **(3)** Deletes the current exemption for certain public facilities to pay licensing fees, including the U.C. Hospitals; **(4)** Provides the DHS authority to raise fees outside of the Legislature (page 7 of language, Section 12666(b)(3)); **(5)** Provides authority to charge facilities late renewal fees and to make penalty payments if their license expires; **(6)** Eliminates fees for CNAs as noted; **(7)** Establishes a fee structure which would require the payment of fees based upon the Budget Act appropriation, and many others.

Proposed Fees From "Right-Sizing" Are not Workable (See Handouts). Due to all of the various adjustments as noted above, the "right-sized" fees increase substantially for many facilities. **A *few* of these are noted below**:

Table: *Examples* of Fees to Be Paid Under "Right-Sizing"

Type of Facility	Current Fee (Rounded) for 2005-06	New Fee (Rounded) for 2006-07	Difference
Psychology Clinics	$30 (set in statute)	$3,077	$3,047 per facility
Primary Care Clinics	$30 (set in statute)	$1,025 3-year phase-in becomes $3,077	$995 per facility then $3,047
Hospice Fee	$622	$3,075	$2,453 per facility
Home Health Agency	$677	$4,717	$4,040 per facility
ICF-DD H and N (6 Bed Facilities)	$380 per facility	$3,732 $622 per bed	$3,352 total difference
Dialysis Clinic	$300	$3,077	$3,047 per facility

Subcommittee Staff Recommendation. ***First***, it is important to note in discussing this newly proposed fee structure, that $20 million in new expenditures, as noted above, have been added into the equation for 2006-07, as compared to 2005-06. **These new expenditures have merit or are required by federal law. But should they all be *"fee"* supported, along with making several other "right-sizing" changes, all in one year? Too many adjustments and changes are being attempted in too short of a timeframe. A transition period is needed to work out additional details including more accurate time-keeping on the part of the DHS L&C to know more definitively how many hours are spent at certain types of facilities.**

Second,* the amount of General Fund presently used to subsidize the DHS L&C activities has actually never been fully clear since under the existing fee structure all collected fees are placed into the General Fund and then appropriated for DHS L&C purposes.** In fact, this is why the DHS often took vacant positions from this Division and used them to meet "unallocated" General Fund reduction drills as discussed in the May 8th Subcommittee hearing. **At this point in time it is estimated that about $7.1 million (General Fund) is being used to support the DHS L&C functions** along with $37.5 million in fee revenue (plus federal funds and a few small special funds). **Of this amount, about $2.7 million in General Fund support is serving as an "offset" to the fees that would otherwise have to be paid by facilities now, under the *existing

fee structure. The remaining portion of this General Fund support is presently used to pay for State-Operated facilities such as State Hospitals (licensed) and Developmental Centers (licensed and certified) as proposed to be continued under the Administration's "right-sizing" proposal. **Therefore, this previous "offset" amount (about $2.7 million) is now being proposed to be paid for in new fees, along with the additional $20 million in new costs.** Absorbing these many fiscal adjustments and policy changes to the fee structure is simply too much in one year.

Third, in order to provide for *a transition period*, it is **recommended to shift $9.975 million from the Licensing and Certification Fund (to be established) to General Fund support by assuming the following criteria as noted below. By providing this adjustment, it means that about 56 percent of the new adjustments (i.e., $20 million increase and recognizing the $2.7 million previous offset for a total of $22.7 million) would still be supported by fees**.

- Leave ICF-DD/H and ICF-DD/N facilities (6-beds only) at a per facility level, not a per bed level, and assume a 2006-07 rate of $1,000 (a revised fixed rate). The Administration's level would have been $3,732 per facility.
- Establish a fixed facility amount for Home Health Agencies and set it at $2,700. The Administration's would have been $4,717.
- Establish a fixed facility amount for psychology clinics of $600. The Administration's would have been $3,077.
- Establish a fixed facility amount for primary care clinics of $600. The Administration's would have phased the rate in over a three-year period from $1,025 (for 2006-07) up to $3,077 (for 2008-09).
- Establish a fixed facility amount for specialty clinics (non-profit rehabilitation) at $500. The Administration's would have been $3,077.
- Establish a fixed facility amount for hospice facilities at $1,000. The Administration's would have been $3,075.
- Due to the nature of the existing model whereby certain facilities subsidize others, by shifting some of the cost of these proposals from fees to General Fund support, their proposed new level of fee is reduced as well, as compared to the Administration's. This includes most notably skilled nursing homes ($213 per bed compared to the Administration's $224 per bed).

Fourth, various clinic providers are concerned that the DHS still has not meet requirements contained in AB 951 (Florez), Statutes of 2001, particularly those that pertain to streamlining various aspects of licensure application processing. Therefore, it is also recommended to adopt the following uncodified trailer bill language to at least improve the accountability of the DHS in this area: "The Department of Health Services shall report to the Legislature by no later than February 1, 2007 on its progress in meeting the requirements contained in AB 951, Statutes of 2001.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. **DHS,** Please step through the details of the "right-sizing" proposal, including **key changes** as compared to the existing methodology used now.
2. **DHS** Please clarify what core activities still need to be accomplished in order to comply with AB 951 (Florez) and when will they be completed?

PUBLIC HEALTH ISSUES (*Discussion Items*)

1. AIDS Drug Assistance Program (issue 369)

Governor's May Revision. The May Revision proposes two adjustments—one for the current year and one for the budget year.

First, a reduction of $8 million (General Fund) is proposed for 2005-06 as a result of efforts to reduce costs by incorporating a new reimbursement structure into the Pharmacy Benefits Manager contract and revising the guidelines regarding Medi-Cal screening of potential ADAP clients. The Administration states that these current year savings will not affect California's ability to achieve its federal maintenance of effort requirement.

Second, for the budget year the May Revision proposes a need of $23.9 million (total funds); however, a *net* increase of only $3 million (ADAP Drug Rebate Fund) is being requested due to anticipated savings in the program of about $20.9 million.

The proposed increase is requested in order to add a new anti-retroviral to the ADAP formulary. This new anti-retroviral (a protease inhibiter now known as TMC-114) will likely be priced above other similar drugs, necessitating this adjustment. It should be noted that costs for this new drug are partially offset by additional program savings expected to total $20.9 million.

The proposed savings will be a result of three main factors: (1) the implementation of the Medicare Part D Drug Program; **(2)** the new reimbursement structure in the updated Pharmacy Benefits Manager contract; and **(3)** the revision of the guidelines regarding Medi-Cal screening for potential ADAP clients. According to the DHS, this estimate of savings is based on actual expenditures through February 2006 and gives only two months worth of Medicare Part D Drug Program data. As such, the savings estimate will likely need to be updated when more information is available.

The rebate funds are based on collection history and the DHS is confident it will successfully collect the projected rebate amount. However, rebate revenue is projected to decrease slightly, as compared to other years.

Subcommittee Staff Recommendation. It is **recommended to adopt** the May Revision proposal.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

2. The Indian Health Program *(See Hand Out)*

Issue. The budget proposes total expenditures of about $6.5 million (General Fund) to fund 31 health entities (29 primary care clinics and two health care organizations that provide regional health education program services). (See hand out for current allocations of these funds.) Funding for the program is contingent upon appropriation in the annual Budget Act. This program has not been increased for several years.

The Subcommittee is in receipt of information requesting an increase of $1.9 million (General Fund) for the program. The purpose of these funds would be to add 9 new clinics to the program, for about a 30 percent increase in the number of clinics funded. These clinics will be able to apply for funding in 2006-07; however, existing clinics also need to maintain their level of funding.

Indian health clinics are selected for program participation through a Request for Application process which is released on a three-year cycle. During this time, new clinics are eligible to apply for participation in the program. Funding for continuing and new clinics is determined by an allocation formula. Funding for new clinic awards is dependent on the total program funds available and has ranged from $40,000 to $80,000 per clinic for their first year. Funding for new clinics in subsequent years is determined by the program's clinic allocation formula.

Background—the State's Indian Health Program. The purpose of this program is to improve the health status of American Indians and Alaskan Natives living in urban, rural, and reservation or rancheria communities throughout California. Health services for American Indians are based on a special historical legal responsibility identified in treaties with the U.S. government.

Existing state statute provides for the Indian Health Program administered by the DHS. The program provides various services and conducts various activities including the following:

- Provides $6.4 million in funds to 29 primary care clinics for health care services, including dental services;
- Provides assistance in how to maximize third-party payment systems
- Manages 7 HIV testing and counseling grants;
- Provides technical assistance including quality of care reviews, program planning and evaluation assistance; and
- Provides assistance with federal studies, including the examination of options for the development of health care services to AI/AN individuals residing in Los Angeles County.

Background—Population Characteristics. The DHS states that California has about 627,500 American Indians and Alaskan Natives (AI/AN) living in California (as of 2000). This includes 333,000 people who classify themselves as AI/AN, and an additional 294,200 people who classify themselves as AI/AN, and one or more other races. The AI/AN population in California is comprised of members of indigenous California tribes as well as members of tribes from throughout the United States. There are more than 107 indigenous California tribes, representing about 20 percent of the nation's approximately 500 tribal groups.

Subcommittee Staff Recommendation. It is **recommended to increase by $1 million** (General Fund) for this important program.

Questions. The Subcommittee has requested the DHS to provide technical assistance by responding to the following questions.

1. **DHS**, Please briefly describe the existing program and clinic services provided.
2. **DHS**, Based upon the existing population and need for health care services, is there likely a need for increased funding?

3. Joint Proposal from the EMSA and DHS—Health Care Surge Capacity (See Hand Out) (issues 100 and 360)

Governor's May Revision. The May Revision **proposes total increased expenditures of $400.4 million ($400 million General Fund, and $424,000 Licensing and Certification Funds). Of this amount, $32 million ($31.6 million General Fund and $424,000 Licensing and Certification Funds) is proposed to be ongoing expenditures (for 2007-08).** In addition, trailer bill language is proposed to require general acute care hospitals, as a condition of state licensure, to participate in emergency preparedness planning with the local health department.

This $400.4 million proposal consists of $12.3 million for the Emergency Medical Services Authority (EMSA) and $388.1 million for the Department of Health Services (DHS).

EMSA Mobile Field Hospitals--$12.3 million. ***First,*** **$12.3 million would be expended by the EMSA to purchase two Mobile Field Hospitals and related equipment, and to support three new positions--**two Health Program Specialist I's and a Health Program Manager I. The positions are requested to support the Mobile Field Hospitals and provide for training, emergency exercises and drills regarding their deployment.

The EMSA expenditure for equipment of $11.1 million, including the two Mobile Field Hospitals is as follows:

- $6.670 million for two Mobile Field Hospitals;
- $3.3 million for ventilators for use in the Mobile Field Hospitals;
- $700,000 for Hepa air filters for use in the Mobile Field Hospitals;
- $400,000 for a flat bed truck; and
- $40,000 for a forklift.

The Mobile Field Hospitals would be used to supplement the capacity of damaged or overburdened hospital facilities. These hospitals are self-contained with heating/ventilating and cooling systems, medical gases, and full genitor power rendering the units operable in all climactic conditions. **They would be supplied with all requisite medical equipment and supplies. One of the hospitals would be positioned in Northern California and the other in Southern California. The EMSA states that these hospitals can be deployed within the first few days of an event, long before military hospitals or other major federal resources would be available.**

Each hospital has a capacity of 200 beds and modules for:

- Advanced trauma life support, surgical operating rooms, intensive care and isolation;
- Patient holding areas, wards, nursing stations, central medical service areas, and administration;
- Ancillary medical services including laboratory, X-ray and pharmacy services.

During an event, the EMSA would set up and operate the hospitals using a combination of state personnel, contracted logistic support staff, and organized disaster medical volunteers. The EMSA states that they would fully coordinate this program with the Office of Emergency Services (OES), CA National Guard, and the DHS.

The three requested EMSA staff would, among other things, perform the following key functions:

- Research and develop policies and procedures with the DHS, OSHPD, OES, the Joint Commission on Accreditation of Healthcare Organizations, local emergency medical services agencies and various constituency groups, regarding the use of the Mobile Hospitals;
- Research and purchase medical equipment, consumable medical supplies, and related materials;
- Participate in the administrative management of the Mobile Field Hospitals;
- Oversee development of state plans and local guidance (such as threat assessment and operational protocols for local emergency medical systems and mutual aid regions);
- Participate in meetings and conferences relating to chemical, biological, radiological, nuclear or explosive threats at local, state and national levels; and
- Manage a variety of administrative tasks necessary to develop and manage the program, such as managing consultants, volunteers and the program budget.

DHS—Proposed Expenditure of $388.1 million. The DHS proposes expenditure of funds in several components. Each of these components is discussed below. It should be noted that the DHS is seeking exemption from public contract code requirements under this entire program.

- *Rapidly Develop State Guidance and Standards--$5.2 million.* Under this component, the DHS proposes the use of **(1)** $5 million for consultant contracts to develop statewide guidance and standards as discussed below, and **(2)** $224,000 to support two state staff—an Associate Governmental Program Analyst and a Staff Services Manager III for this project. Of the proposed amount, $218,000 (General Fund) would be ongoing to support the DHS staff.

  Presently, the DHS has the authority to grant hospitals flexibility in meeting licensing requirements during an emergency. For example, under Patient Accommodation regulations, the DHS may grant temporary permission to house patients in space that has been previously approved for patient care. In a declared emergency, many statutory or regulatory requirements can be suspended altogether. However, the DHS believes that specific work ends to be done to provide a better framework for emergencies.

  The DHS states that medical, hospital and local health department leaders have indicated that state guidance on the specific licensing flexibility, liability protection, and reimbursement that will be provided to health facilities, professionals and volunteers during an emergency response effort is needed. The DHS contends that without information on what standards might be changed and under what conditions these changes would occur, local governments and health care leaders are unable to plan effectively for the specifics of their community's response. Hospitals have express a desire for surge planning templates and standardized training curricula and exercises.

The DHS states that, among other things, the standards and guidelines would address areas of concern such as (1) identification of regional boundaries for hospital surge planning; (2) ways to increase staffing in emergencies; (3) standards for pre-hospital and hospital austere care; (4) guidelines and templates for hospital surge capacity plans; and (5) reimbursement issues for care givers.

- *Develop and Maintain Hospital Surge Plans--$14.5 million.* Under this component, **the DHS proposes to fund hospitals (public and private), via local health jurisdictions, to develop and maintain hospital surge plans, including plans for surge staffing, infection control, equipment needs, systems for managing volunteers, training and exercises.** The DHS would require hospitals to have documented operational plans. In addition, the DHS is proposing trailer bill language to require, as a condition of licensure, for hospitals to participate in emergency preparedness planning with local health jurisdictions.

  The ongoing expenditures of this proposal are $29 million (General Fund) in 2007-08 and annually thereafter.

  Table—DHS Proposed Funding of Hospital Staff

Hospital Size	Number of Hospitals	Funded Positions ($100,000 each)	Total Annual Funding for Staff (Ongoing)
200 plus beds	162	162 positions (1 each)	$16.2 million
50 to 199 beds	216	108 positions (0.5 each)	$10.8 million
Less than 50 beds and sole hospital in area	20	5 positions (.25 each)	$500,000
County groups of hospitals with less than 50 beds	15	15 (1 each)	$1.5 million
Total Annual Costs	**413**	**290 staff**	**$29 million**

  The funds for the hospital positions would be provided to the local health jurisdictions who would then allocate it to the appropriate hospitals. The DHS states that hospitals would be responsible for developing and maintaining documented hospital surge plans including:

  - Planning for a large influx of patients in a short timeframe;
  - Specifying triggers for actions such as canceling elective surgeries, early discharges, and redirection of patients;
  - Developing procedures for managing volunteer medical and non-medical staff;
  - Ensuring ample supplies of equipment and processes for purchasing additional supplies during emergency situations;
  - Developing procedures for recalling staff and analysis of other staffing options; and
  - Developing training plans and schedules to ensure staff are ready to respond during a public emergency.

- *Update Hospital Licensing Regulations--$424,000 (L & C Fund).* Under this component the DHS would use 3.5 positions (two-year limited-term)—a Staff Counsel, 1.5 Nurse Consultant III's, and a Health Facilities Evaluator Nurse- to update hospital licensing and infection control regulations to address preparedness for major emergencies or disasters. **In addition, the DHS is proposing Budget Bill Language to enable them to promulgate these regulations on an emergency basis.**

- *Purchase Courses of Anti-Viral Drugs for Pandemic Influenza--$53.3 million (General Fund).* Under this component, a total of 3,723,339 courses of antivirals would be purchased. General Fund support is proposed for this since federal bioterrorism funds cannot be used for this purpose. However, California's federal bioterrorism funds would be used to rent warehouse space in a single location to store the antivirals. The DHS states that the federal CDC recommends for California to purchase this level of treatment courses.

  The DHS states that about 90 percent of the funds would be used to purchase Tamiflu (3,351,005 courses at $14.11 per dose) and 10 percent to purchase Relenza (372,334 courses at $16.29 per dose). The antivirals would be purchased using a 25 percent federal discount.

  It should be noted that other purchases of antivirals have also been authorized, including the following:

  - $1.3 million (General Fund) as contained in the January budget and as adopted by the Subcommittee (68,062 courses);
  - $460,000 (General Fund) as contained in SB 409 (Kehoe) as enrolled (24,455 courses); and
  - $37,748 as previously purchased by the DHS (616 courses).

- *Purchase Ventilators-- $99.8 million (General Fund).* Under this component the DHS would purchase 7,183 ventilators at a cost of $10,000 per ventilator, plus tax, freight and a five-year maintenance agreement (at $2,800 per ventilator). Storage with a vendor manager, who would maintain ventilators in one Northern California location and one Southern California location, are also included. The storage expenditures of $300,000 would be ongoing. Specifically, the proposed expenditures are as follows:

  - $79.4 million for the 7,183 ventilators, including tax and freight;
  - $20.1 million for; and
  - $300,000 annually for vendor management of the ventilators.

  The DHS states that "under pandemic conditions" the number of patients needing ventilator support will far outstrip capacity. Specifically they contend that 34,028 ventilators would be needed under these conditions. Presently there are 7,183 surge ventilators available. The May Revision proposal would double the capacity to a total of 14,366 being available.

- *Purchase Medical Supplies for Alternate Care Sites-- $164.4 million (General Fund).* The DHS would purchase supplies and equipment for "alternate care sites". These funds would be used to help local health jurisdictions develop communitywide and regional pandemic-level surge capacity. The DHS states that supplies needed to operate alternate care sites depend on the types of beds to be set up at each site. For medical-surgical beds, a cache of supplies averages about $400 per patient. For intensive care beds, the cost of supplies rises to $4,000 per patient.

  Table—DHS "Alternate Care Sites" Proposed Expenditures

Supplies	Quantity	Total Cost (purchase, tax & freight)
ICU Beds	36,423 beds	$161.4 million
Medical-Surgical Beds	4,969 beds	$2.2 million
Warehouse Storage (3,000 sq feet @$1.00 per region per mth)	6 regions	$216,000
Local staff to maintain local caches.	6 half-time staff ($50,000 each)	$275,000
DHS staff to manage project	3 staff (Staff Manager II, two AGPAs)	$321,000
TOTALS		**$164.367 million**

- *Purchase Masks for Healthcare Workers--$50.5 million (General Fund).* According to the DHS, assuming that 37.5 percent of the reported 500,000 healthcare workers have direct patient contact, and assuming that 3 mask changes per day would be needed, a total of 562,500 masks would be required on a daily basis. **Assuming that a stockpile would be needed for the first 180 days, the DHS states that 101,250,000 masks would be needed. Therefore, $50.5 million is proposed to purchase these masks, including the cost of the mask (45 cents per mask), tax and shipping.**

- ***Budget Bill Language for EMSA and DHS Exemption from Contract Code.*** The May Revision also proposes Budget Bill Language that would exempt both departments from public contract code requirements due to "the need to rapidly acquire, store and manage the medical supplies and equipment to respond in times of emergency or in the event of outbreaks of highly communicable disease such as pandemic influenza."

Background—Use of DHS Federal HRSA Grant Funds. The DHS has been receiving federal HRSA grant funds for four years (federal funding cycle with the fourth year ending August 2006) and as presently crafted by Congress, these grants are scheduled to continue. It should be noted that the HRSA grant funds have designated "priority areas" for which each state is required to expend the funds. Each priority area then has more detailed "benchmarks" within them. Based on information provided by the DHS, the state has expended or encumbered these federal funds as shown in the bullets below.

- Priority Area 1—Financial Administration of Grants $2.3 million
- **Priority Area 2--Surge Capacity** **$90.5 million**
- Priority Area 3—Deployment of emergency medical services $10.5 million

- Priority Area 4—Linkages to Public Health $3.9 million
- Priority Area 5—Education & Preparedness Training $9.7 million
- Priority Area 6—Preparedness Exercises $2.8 million

TOTAL Amount To-Date (9/02 through 8/2006) $126.9 million (federal funds)

The DHS states that funds have been used to provide 340 of California's 442 general acute care hospitals with surge supplies and equipment including cots, personal protective equipment such as powered air purifying respirators and N-95 masks, generators, medical supplies, pharmaceutical caches, communications equipment, and isolation capacity systems.

Subcommittee Staff Recommendation. Clearly California needs to be prepared. However, as noted by the Legislative Analyst's Office, the level of resources proposed in this May Revision request go far beyond those needed to respond to the types of emergencies that Californians have become accustomed to—wildfires, floods and earthquakes—as well as for some threats that are novel, such as terrorist attacks.

It should also be noted that the Subcommittee has already approved $45.8 million (General Fund) in new resources to address various aspects of preparedness, and the state has been receiving and expending tens of millions annually from the federal CDC grant funds and federal HRSA grant funds to add supplemental funds to California's existing public health system. SB 409 (Kehoe) also provides additional funds of $5.4 million (General Fund) for various current-year pandemic activities including the purchase of some course of antivirals. (This legislature is pending the Governor's signature.)

The Subcommittee staff recommendation assumes that a more gradual phase-in would occur and it seeks to emphasize *containment*. Purchasing a significant volume of antivirals would on the natural, provide considerable assistance as far as establishing a "ring of containment". The table below *(next page)* displays the Administration's proposal, Subcommittee staff recommendation, and the LAO's recommendation for comparison purposes.

With respect to the Administration's proposed trailer bill legislation to require hospitals as a condition of licensure to participate with local health jurisdictions in emergency planning**, it is recommended to deny this language.** The DHS notes that of California's 442 general acute care hospitals, 340 of these hospitals, or 77 percent, already participate with local health jurisdictions in this type of planning. Further, local health jurisdictions are poised to receive an infusion of $16 million (total funds) for various public health functions at the local level. Therefore where needed, they could engage non-participating hospitals through various local means *if* desired.

The DHS and EMSA are also seeking waiver of public contract code requirements via Budget Bill Language for all of the various purchases that are proposed. Since BBL is applicable in one-year increments, it is recommended to provide this authority.

Table Displaying Recommendations on Surge Proposal

Component	Administration	Subcommittee Staff	LAO
Develop state guidance & standards	$5.224 million ($5 m consultant)	Approve	Approve
Hire hospital staff and adopt trailer bill to develop and maintain hospital surge plans.	$14.5 million GF ($29 million GF ongoing)	Deny, including trailer bill	Approve, but use L&C Fund
Update Hospital licensing regulations	$424,000 GF (DHS staff)	Approve, but use HRSA funds	Approve
Purchase Mobile Field Hospitals	$12.3 million GF **2** mobile hospitals	$18.3 million GF **3** mobile hospitals	$6.2 million **1** mobile hospitals
Purchase antiviral drugs	$53.3 million GF	Approve	Approve
Purchase ventilators	$99.8 million GF	$33 million (purchase one-third now)	$81.5 million Used $14 million federal funds-HRSA
Purchase medical supplies for Alternate Care Sites	$164.4 million	LAO	$78.2 million (purchase half)
Purchase masks for health care workers	$50.5 million	LAO	$28.5 million (purchase half)
Total Recommended	**$400.4 million**	**$216.9 million**	**$267.9 million**
General Fund	$400 million	$182.9 million	
Licensing & Certification Fund	$424,000	0 (not available)	$14.9 million
Additional Federal Funds from HRSA	0	Up to $34 million	Up to $34 million

Questions. The Subcommittee has requested the EMSA and the DHS to respond to the following questions.

1. **EMSA**, Please provide a brief summary of your request to purchase and deploy two Mobile Field Hospitals.

2. **DHS,** Please provide a brief summary of each of your components in this proposal.

D. Item 4300 Department of Developmental Services (*Discussion Items*)

COMMUNITY BASED SERVICES ISSUES

1. Regional Centers Baseline Estimate (issue 220)—*For Technical Adjustment Purposes*

***Governor's May Revision*. The May Revision proposes total expenditures of $3.187 billion ($2.1 billion General Fund), a *net* increase of $88.4 million ($56.7 million General Fund) over the January budget, for community-based services provided through the Regional Centers (RCs) to serve a total of 212,225 consumers living in the community.** This funding level includes $487.5 million for RC operations and $2.7 billion for the Purchase Of Services.

Most of the May Revision increase is attributable to (1) an increase in the base utilization of services by consumers, and **(2)** updated expenditure data**.** Of the $88.4 million net increase, $69 million is needed to account for these two factors.

Other key technical adjustments include the following:

- *Three Percent Rate Adjustment (issue #224).* An increase of $582,000 ($436,000 General Fund) to reflect updated costs to provide a 3 percent rate increase to certain service providers, including inclusion of Adult Family Home Agencies and specified Out-Of-Home Respite Services that should have been included in the January budget adjustment. Therefore a total of $68.4 million ($46.6 million General Fund) is provided for the rate adjustment.

- *Self Directed Services (issue #226).* Implementation of this model has been delayed due to its linkage with the roll out of the CA Developmental Disabilities Information System (CADDIS) (Discussed later in this agenda.). Therefore, a reduction of $3.1 million (General Fund) is proposed in RC Operations since staff will not be needed for this activity in the budget year, and a *net* increase of $205,000 (total funds) is needed in RC Purchase of Services since savings in this area had been assumed from the implementation.

- *Adjustment to Autistic Spectrum Disorders Initiative.* The January budget included $2.6 million (General Fund) to provide assistance to consumers with Autism. The May Revision reduces this proposal by $6,000 (General Fund) to reflect a decrease in projected rent costs.

Subcommittee Staff Recommendation. It is **recommended to adopt** the baseline budget for the RCs to account for updated utilization in services and costs, and to account for certain technical adjustments.

(Further adjustments may be taken by the Subcommittee as noted in the agenda below on an issue-by-issue basis.)

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS,** Please briefly describe the *baseline adjustments* to the RC estimate.

2. Proposed Increase for Supported Employment

Issue. In the **April 3rd Subcommittee hearing**, constituency concerns were expressed regarding the need to increase the number of individuals in Supported Employment Programs, including both individual placement and group placement.

Though the budget provides an increase of 3 percent for these programs, this modicum of increase is not sufficient to sustain or expand the number of consumers who want to participate in these employment programs.

Additional Background—Supported Employment Program (SEP). Supported employment provides opportunities for persons with developmental disabilities to work in the community, in integrated settings, with support services provided by community rehabilitation programs. These services enable consumers to learn necessary job skills and maintain employment. SEP provides services for individually employed consumers (individual placements), as well as consumers employed in group settings (group employment).

The caseload is affected by RCs referring consumers for supported employment from "Work Activity" Programs (WAPs), day programs, schools or other programs. Caseload is also impacted by employment opportunities within the community and the ability of consumers to obtain and maintain employment. These factors are critical because these services are only purchased when the consumer is employed.

Subcommittee Staff Recommendation. Based on technical assistance obtained from the DDS**, an *additional* rate increase of 10 percent, for a total increase of 13percent for 2006-07, would require an increase of $6.120 million ($4.266 million General Fund) above the May Revision.**

It is recommended to provide this augmentation and to modify the Administration's trailer bill language on rate adjustments to account for this action.

3. Community Start-Up Funding—"Open" Issue

Prior Subcommittee Action (April 3rd). In a prior hearing, the Subcommittee adopted certain continuing cost containment measures as proposed by the Governor in his January budget and as continued in his May Revision base estimate for the Regional Centers.

An issue that was left "open" by the Subcommittee pertains to the development or "start-up" of any new program unless the expenditure is necessary to protect a consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. This "freeze" on start-up funding has been in existence for 4 years.

The Governor's May Revision continues to freeze these start-up funds for savings of $6 million (General Fund).

Subcommittee Staff Recommendation (See Hand Outs). It is **recommended to (1)** restore $3 million (General Fund) of the May Revision's reduction of $6 million (General Fund) to provide for focused/targeted start-up, ***and*** **(2)** adopt trailer bill legislation (hand out). As noted in the language, these funds would be provided in a focused manner for one-year. The DDS would discern where the funds would be most needed**. The development of new programs is necessary in order to maintain access to a wide variety of community-based options.**

Questions. The Subcommittee has requested the DDS to provide technical assistance by responding to the following questions.

1. **DDS,** from a technical assistance standpoint, would expenditure of these funds in a focused manner be constructive for facilitating the development of community resources?

4. Federal CMS Waiver Update—Need to Provide Additional Case Managers

Issue. In a letter dated **April 21, 2006**, the federal CMS informed the state that their evaluation of the DDS' Home and Community-Based Waiver found the waiver to be in substantial compliance with federal statutory assurances. **However, the letter noted that the state must review and revise as needed, its policies to assure that the case manager to *waiver participant* ratio of 1 to 62 is *consistently* met.**

Based on recent survey data collected in February by the DDS from the RCs, additional staff resources are necessary in order to comply with the federal CMS letter. **However, no additional funding was provided in the May Revision to make adjustments for this letter.** The federal CMS report also recommended the following:

- For the DHS and DDS to jointly evaluate whether RC case managers could benefit from remedial training in essential case management skills; and
- For the DDS to revise the manner in which the case managers to waiver participant ratio is calculated so as to more accurately reflect the actual availability of case managers and to take proactive measures to achieve the mandated ratio of 1 to 62 on a real time basis.

Subcommittee Staff Recommendation. Based upon technical assistance obtained from the DDS, it is recommended to provide an increase of $3.2 million ($1.7 million General Fund) to RC Operations to address the federal CMS concerns with providing appropriate case management. This increase will provide for an additional 43 case manager staff, as well as the appropriate compliment of supervising counselors (4 staff) and clerical support (8 staff). Further, it is recommended to adopt Budget Bill Language to require the DDS to further analyze the needs of the RCs case manager operations to ensure that appropriate staffing is being provided as noted in the federal CMS report. **This proposed language is as follows:**

> Item 4300-001-0001
> Provision x.
> The department shall actively engage the Regional Centers to assess and determine methods for **(1)** improving the training of case managers, **(2)** recruiting and retaining case managers throughout the state, and **(3)** addressing other needs as identified in the federal

Centers for Medicare and Medicaid (CMS) letter (dated April 2006) regarding the state's compliance with the Home and Community-Based Waiver

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS,** Please respond to comments contained within the federal CMS report and address the identified need for increased case manager resources.

5. Impact of Medicare Part D Drug Program on Regional Centers (issue 227)

Governor's May Revision. The May Revision **proposes a total increase of $7.650 million (General Fund) to the RCs for two specified purposes, and Budget Bill Language to facilitate the enrollment of RC consumers into Medicare Part D "prescription drug plans" (PDPs).**

First, **an increase of $4.8 million (General Fund) is requested to pay insurance premiums or buy prescription medications not covered by Part D (whichever is most cost effective) for RC consumers (aged 18 and older) who are dual eligible (Medicare and Medi-Cal).** The DDS states that without these funds, some RC consumers may be unable to access medically necessary prescription drugs, this placing their health and safety at risk. The fiscal estimate assumes that RCs will need to provide up to 15 percent of the cost of medications because these medications would no longer be covered under Medicare or Medi-Cal.

It should be noted that some RC medication expenditures were offset in the current-year because the Medi-Cal Program provided up to a 100-day supply of drugs for dual eligibles who requested this prior to December 31, 2005 (since the new program went into affect on January 1, 2006).

Second, **an increase of about $2.9 million (General Fund) is requested to (1) continue support for existing Medicare Part D Drug program enrollees to access medications and change plans as needed, (2) assist new RC consumers who will be auto-enrolled and will need assistance, and (3) address overall forthcoming Medicare Part D changes.** Resources were provided in 2005-06 to the RCs as a one-time need; however, the DDS states that continued support for consumers is necessary. It is assumed that the RCs will use these funds for contracts with enrollment brokers and necessary clinical staff in order to ensure consumer health and safety.

Third, in order to assist in ensuring the appropriate expenditure of the $2.9 million, the DDS is proposing Budget Bill Language that ties the appropriation with its use. **The language is as follows: "Funds appropriated in this item may only be expended to facilitate the enrollment of Regional Center consumers into Medicare Part D prescription drug plans."**

Additional Background—Medicare Part D Drug Program and RC Consumers. On January 1, 2006, about 36,465 RC consumers were auto-enrolled in Medicare prescription drug plans (PDPs). In preparation for the January 1, 2006 transition, RCs utilized enrollment brokers to assist consumers, families and providers to better understand the new program and facilitate their enrollment in a PDP that best meets their needs.

PDPs are not mandated to offer the same range of medications previously covered under the Medi-Cal Program. Some, but possibly not all, medications are covered under any one plan. Thus, there is no guarantee that necessary medications are available under the Medicare PDP. Consistent with usual cost containment measures, PDP formularies generally are more restrictive than Medi-Cal prescription coverage.

Currently, some classes of drugs are excluded under the Medicare Part D Drug Program which were covered under Medi-Cal previously. For example, Medi-Cal currently covers over-the-counter cough and cold medicines. These products will not be covered by the new Medicare PDPs. On average, 85 percent of the drugs covered by Medi-Cal prior to implementation of the Medicare Part D Drug Program continue to be covered by the Medicare PDPs and Medi-Cal. Therefore, about 15 percent are not covered.

Legislative Analyst's Office Recommendation. The LAO concurs with the need for the proposal. However, they are also recommending adoption of the following reporting Budget Bill Language for reporting purposes.

> Item 4300-001-0001 (state support)
> *Provision x.* The Department of Developmental Services shall provide to the Legislature by April 1, 2007, expenditure data for the costs of drugs purchased by Regional Centers and for the costs of Medicare Part D insurance premiums between July 1, 2006 and January 1, 2007, for Regional Center consumers eligible for the Medicare Part D drug benefit and projections for the rest of the calendar year.

Subcommittee Staff Recommendation. It is recommended to approve the May Revision in order to maintain consumer health and safety, and to adopt the LAO's recommended Budget Bill Language.

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS**, Please provide a brief summary of the request.

6. RC Resources to Increase Federal Funds & Offset General Fund (issues 231 & 250)

Governor's May Revision. The May Revision proposes several adjustments in order to capture increased federal reimbursement which is available under the Home and Community-Based Waiver to offset General Fund support. **In order to collect about $21.4 million annually in federal reimbursement, the state must provide the federal CMS with detailed billing data on each individual RC consumer who is eligible to access services under the Waiver.** This would not be problematic if the CA Developmental Disabilities System (CADDIS) was operational. (The CADDIS issue is next on the agenda.)

However until it is operational, the DDS states that adjustments are necessary in order to capture federal reimbursement and offset General Fund support. **Specifically, the following adjustments**

are proposed (assumes an implementation date of October 1, 2006) that will result in a *net* savings of about $13.5 million General Fund for 2006-07:

- *RC Operations—Increase of $2.1 million ($1.4 million General Fund).* **This adjustment would provide two staff—an Account Clerk II and a Community Program Specialist I—at each of the RCs (42 staff total) to:** (1) re-negotiate contracts with vendors; (2) support, promote and train vendors and RC personnel involved in the billing process; (3) work with DDS on changes required to expand and enhance existing billing options that will provide required data; (4) key enter necessary attendance data and other required billing data from paper invoices from vendors; and (5) review and correct attendance data after data is uploaded to existing information system to assure proper payment to vendors.

- *Vendor/Provider Resources for Administrative Activity—Increase of $1.3 million ($1 million General Fund).* The DDS has identified a set-aside of $1.3 million ($1 million General Fund) to provide up to a 1 percent increase in the re-negotiated contracts with vendors/providers to cover the increased workload they will incur for capturing and reporting the data required to support Waiver billing to obtain the federal reimbursements for the state. The DDS proposes allocating these funds to the RCs for the vendors only after receiving information from the RCs verifying that required contract re-negotiations and/or alteration in the vendor's billing practices have occurred.

- *DDS Headquarters—Increase by $193,000 ($126,000 General Fund).* This increase would be used to support two limited-term Associate Governmental Program Analyst positions to manage the additional Home and Community-Based Waiver related reimbursements for contracted services and to oversee the operation at the RC level. These positions would be used until CADDIS is in place, which would then replace this manual system. The workload includes various activities such as: (1) analyzing contracted services to ensure collection levels that maximize the capture of federal funds; (2) reconciling projected billable amounts; (3) overseeing the operation at the RC level; (4) supporting and training vendors and RC staff in the use of "e-attendance" and "e-billing"; and (5) coordinating with the federal CMS and the DHS staffs as necessary.

- *Fund Shift (Decrease of $16.1 million General Fund and Increase of $16.1 million Federal).* The DDS assumes that 9 months of billing data can be obtained during 2006-07 (October 1, 2006 effective date) and that about 32 percent of the RC caseload is eligible to be billed under the Home and Community-Based Waiver. Based on these assumptions, a savings of $16.1 million General Fund is assumed with a corresponding increase in federal reimbursements.

- *Trailer Bill Language.* The Administration is proposing trailer bill language to ensure that the proposed 1 percent funding for vendors/providers is used appropriately to obtain the detailed billing information in order for the state to receive the federal reimbursements. **The proposed trailer bill language is as follows:**

  Add Section 4694 to Welfare and Institutions Code.

  "Effective July 1, 2006, all regional center vendors who are qualified providers under Title XIX of the Social Security Act and are serving individuals enrolled under the Home and Community-based

Services waiver program for persons with developmental disabilities, shall ensure that billing information provided to regional centers identifies the individual consumer(s) and, for each consumer, the specific dates of service, location of service, service unit, unit costs and other information necessary to support billing under the Home and Community-based Services waiver. Regional centers must also ensure that their contractual and other billing and payment arrangements with providers require the provision of such information to support billing under the Home and Community-based Services waiver program. Resources provided to regional centers, pursuant to the Budget Act of 2006 and following, to implement this provision shall be allocated to the regional centers only until implementation of a statewide electronic data system that collects the billing information necessary to support billing under the Home and Community-based Services waiver program."

- *Budget Bill Language—Two Provisions.* The DDS is also proposing to add two provisions of Budget Bill Language to the RC appropriation (Item 4300-101-0001). One provision pertains to the RC Operations appropriation for staff and the second provision pertains to the $1.3 million in set-aside funds to be used to augment service vendor/provider rates as previously discussed above. **The two pieces of language are as follows:**

  Add to Item 4300-101-0001.
  Provision 6. $2,148,000 of the funds appropriated in this item shall be used by RCs to begin collecting the information required for reimbursement by the Home and Community-Based Waiver from those service providers who are qualified providers under Title XIX of the Social Security Act, who are not currently providing the required information, and who are serving individuals enrolled under the Home and Community-Based Waiver program. RCs shall give the highest priorities for utilizing these funds to obtain this information from transportation vendors and other vendors with the highest annual costs.

  Provision 7. $1,317,000 of the funds appropriated in this item may be used to augment service provider rates for workload necessary to obtain information to secure federal participation under the Home and Community-Based Waiver. Eligible providers are those service providers who are qualified providers under Title XIX of the Social Security Act who are not currently providing the required information and who are serving individuals enrolled under the Home and Community-Based Waiver program.

Additional Background—Availability of Federal Reimbursement. Presently, the state is *not* collecting about $21.4 million annually in federal funds for certain transportation costs that could be obtained under the Home and Community-Based Waiver. This is because these transportation services are billed as a contract service and not individually, as required by the federal CMS in order to obtain the federal reimbursement for these services.

The DDS operates the Home and Community-Based Waiver which enables the state to provide a broad array of home and community-based services to eligible individuals who, without these services, would require a level of care provided in Intermediate Care Facilities (ICFs). Under this Waiver, the state can obtain a 50 percent federal reimbursement rate for consumer services. The Waiver has been in existence since 1995 and has grown substantially to now include up to 75,000 consumers (cap as of October 1, 2006) and expenditures of about $1.453 billion ($726.9 million General Fund).

Subcommittee Staff Recommendation. It is recommended to **adopt the May Revision.**

Questions. The Subcommittee has requested the DDS to respond to the following question.

1. **DDS**, Please provide a brief summary of the request.

7. CA Developmental Disabilities Information System—Administration's Adjustments

Prior Subcommittee Hearings (April 3rd and April 24th). In two prior hearings, the Subcommittee has discussed the CA Developmental Disabilities Information System (CADDIS) and the significant issues which have plagued this project, including the loss of over $50 million in federal reimbursements over a two-year period.

Two key outcomes from these hearings were the recommendations of the Subcommittee for the DDS to: (1) Craft a proposal to draw down additional federal reimbursement for services under the Home and Community-Based Waiver that can be done without CADDIS implementation; and **(2)** Provide the Subcommittee with a plan as to how the Administration wants to proceed after evaluating all of the various options and detail on the project, as provided by consultants and other Administration staff (various information technology specialists from the DOF, CHHS Agency and other areas of state government). The DDS has responded to the first issue with a May Revision proposal to capture a net savings of $13.5 million General Fund, as discussed under Agenda item #6, above.

The following May Revision proposal is in response to the second issue raised—how does the Administration want to proceed regarding this project? The May Revision proposal is based upon a revised "project plan" provided to legislative staff and others on May 5, 2006.

Governor's May Revision. The **Administration is proposing to (1)** re-appropriate $2 million (General Fund) from the existing project funds for activities to complete a Special Project Report or for activities necessary to proceed with CADDIS, **(2)** Budget Bill Language which defines the parameters on how the funds in 2006-07 can be spent, and **(3)** Budget Bill Language that provides for the ability of the DDS to contract with the CHHS Agency's Office of System Integration (OSI). All of these proposed actions are within the Department of Developmental Services budget item.

In addition, there is a conforming action for OSI that would provide an increase of $1.1 million (Reimbursements from the DDS from the reappropriation) for two limited-term positions ($194,000), $863,000 for contracted consulting, and $28,000 for operating expenses and equipment. The purpose of these funds is to conduct an in-depth assessment to determine the technical viability of the system, and estimated costs and time needed to complete the project. The positions are a Career Executive Assignment III and a Staff Information Systems Analyst. The $863,000 in contracts would be allocated as follows: (1) $213,000 for a technical engineer, (2) $400,000 for a technical assessment, and (3) $250,000 for a Special Project Report consultant.

The proposed DDS May Revision changes—all proposed through three pieces of Budget Bill Language—are as follows. These pieces include (1) reappropriation language, (2)

notification to the JLBC if additional funds are needed in the budget year, and (3) language to contract with the CHHS Agency OSI.

The DDS, LAO and DOF have been working to craft a compromise to these pieces of language. These are contained in the *Hand Out.*

Subcommittee Staff Recommendation. It is **recommended to adopt the three pieces of Budget Bill Language as modified by discussions .** The package of BBL enables the DDS to have the technical analysis done and if it is positive, proceed with making changes to "go forward" with the project. Without this language, further delays would occur that would not be beneficial to the state.

Questions. The Subcommittee has requested the DDS to respond to the following questions.

1. **DDS**, Please provide **a brief update regarding the key aspects of the "go forward" proposal, including the importance of resolving the source code issue.**

State Developmental Centers—Discussion Issues

1. Developmental Centers—*May Revision Adjustments*

Governor's May Revision The budget proposes total expenditures of $702.7 million ($385 million General Fund) to serve 2,828 residents who reside in the DC system. This reflects a caseload increase of 31 residents and a *net decrease* of $3.9 million (an increase of $1.6 million General Fund) as compared to the January budget. The increase in caseload reflects the delayed closure of Agnews Developmental Center, from June 30, 2007 to June 30, 2008, as previously discussed.

The *key* adjustments are as follows:

- A net decrease of $496,000 (total funds) is reflected due to standard staffing adjustments that account for population and resident needs for clinical assistance.
- An adjustment of Medi-Cal eligibility rate from 86.23 percent of residents to 85.68 percent of residents results in a decrease of $1.4 million General Fund and a decrease of $1.4 million in reimbursements (federal funds received from the DHS for Medi-Cal).
- An increase of $1.1 million ($642,000 General Fund) which is a one-time only adjustment provided in 2006-07 to aggressively pursue settlement of existing worker's compensation claims through the compromise and release process thereby reducing the DDS' long-term liability.

Subcommittee Staff Recommendation. It is recommended to adopt the May Revision. No issues have been raised.

Questions. The Subcommittee has requested the DDS to respond to the following question.

1. **DDS,** Please provide a brief summary of the May Revision for the Developmental Centers.

E. Item 4400 Department of Mental Health (*Discussion Items*)

1. AB 3632 Mental Health Services to Special Education Students *(See Hand Out)*

Governor's May Revision. The May Revision **proposes substantial changes** to the structure of mental health services provided under the AB 3632 program. **Specifically, the Administration is proposing the following changes:**

- **Suspends the two mandates for two years, beginning as of July 2006.**
- **Establishes a new categorical program within the DMH as of July 1, 2006** which would use General Fund support to match existing federal special education funds within the Department of Education's budget.
- **Increases by $69 million (General Fund) within the DMH appropriation which is to be allocated to County Mental Health agencies and utilized as a match by them to then draw down the available federal Individual with Disabilities Education Act (IDEA) federal funds to provide AB 3632 services.**
- Continues to designate $69 million of federal IDEA funds within the CA Department of Education item, as well as continues the $31 million (General Fund) in "pre-referral" funds (i.e., to be used by schools prior to the AB 3632 program process.).
- **Proposes extensive trailer bill language to, among other things, (1)** establish an allocation method for the $69 million, **(2)** require County Mental Health agencies and the County Office of Education to enter into contracts for the provision of AB 3632 services, **(3)** caps the costs claimed by County Mental Health agencies for service provided under the AB 3632 program at the Medi-Cal Program rate (i.e., "statewide maximum allowance), **(4)** establishes a "risk pool" to address high cost incidents, **(5)** requires the CA Department of Education to audit County Offices of Education to ensure that mental health services provided to special education students are necessary, (6) requires County Mental Health agencies to provide specified information to County Offices of Education and the DMH in order to be reimbursed for the AB 3632 services provided, and **(7)** requires that, in the aggregate level, expenditures of federal IDEA funds by each County Office of Education shall be equivalent to the expenditures of General Fund appropriated in the Budget Act.
- **Provides $275,000 (General Fund) to the DMH to support three new positions to do oversight, training, data collection and other functions as they pertain to this proposal.**

Constituency Concerns. The Subcommittee **is in receipt of several letters expressing considerable concerns with the Administration's proposal from both a funding perspective (under budgeted) as well as a policy perspective. First**, a program restructuring as significant as this would take significantly more than a few weeks to implement (Administration assumes a July 1, 2006 date). **Second**, it does not provide funding for the full costs of the program (also noted by the LAO). **Third**, it is unclear as to what is meant by "using the $69 million (General Fund) as match for the $69 million in federal IDEA which schools receive. **Fourth,** without the mandate on counties, there would no longer be a legal obligation for counties to provide the services, and they would no longer be able to submit SB 90 mandate claims for reimbursement for

unreimbursed costs. **Fifth**, there is insufficient time for County Mental Health agencies to enter into memorandum of understanding with relevant Local Education Agencies.

They also note that the Administration has proposed significant changes without discussions or meetings convened with various stakeholder groups.

Recent History of AB 3632 Funding. Funding for this program has been cobbled together from state mandate claims, General Fund support budgeted within the DMH, and federal Individuals with Disabilities Education Act (IDEA) funds allocated to County Offices of Education. **The table below displays the recent history regarding state mandate claims.**

Fiscal Year	State Mandate Claims Budgeted	State Mandates Claims Filed by the Counties
2001-02	$85 million	$105.7 million
2002-03	$0	$125 million
2003-04	$0	$67 million
2004-05	$0	$82.5 million
2005-06	$120 million	$84.5 million

The DMH was also provided categorical funding which was first included in the DMH budget in 1986-87 and allocated out to County Mental Health agencies. A static funding level was set at $12.3 million in 1992-93 until 2002-03 when this amount was eliminated. In addition, if an AB 3632 child and any associated services are Medi-Cal eligible, County Mental Health agencies will access state and federal Medi-Cal funds *before* utilizing AB 3632 funds. (The DMH states that in 2003-04, $86 million in Medi-Cal funding was accessed.)

With respect to education funding, beginning in 2003-04, $69 million in federal IDEA funds were required to be provided on an annual basis to be used exclusively for the AB 3632 program. For 2004-05 and 2005-06, the Budget Acts also each appropriated $31 million (General Fund) to Local Education Agencies (LEAs) to perform short-term, school-based services before referring a child to their local County Mental Health agencies for AB 3632 services ("pre-referral" services).

What Mental Health Services Are Mandated: Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

Legislative Analyst's Office Comments. First, the LAO believes that the establishment of a categorical program has merit but that the July 1, 2006 date is unrealistic. Second, they also believe that the suspension of the mandate for two years is not workable since it would not provide enough time to conduct a meaningful evaluation of the proposed changes. They contend that schools and mental health agencies may not be willing to make the full commitment needed if the suspension is only for two years.

The LAO also raises numerous issues regarding the Administration's trailer bill language, including issues which they believe are not fully addressed in the Administration's language. **These include the following:**

- How funding for the categorical grant program would change over time, if at all, for caseload and cost factors;
- What would the size of the proposed "risk pool" be when costs of care exceed available funding;
- What are the minimum allocations of categorical program funding to be provided to each county;
- What are the scope of services the state would support with categorical funds;
- How would the new program be evaluated; and
- How would funding responsibilities shift to schools once the DMH categorical funding was exhausted.

The LAO also notes that the program is *under budgeted* for 2006-07. As noted earlier, the Administration proposes a total of $138 million for AB 3632 ($69 million General Fund support and $69 million federal IDEA funds). The LAO believes annual costs to be about $172 million. They note that the Administration's intention is that any cost in excess of the $138 million, after efficiencies have been achieved, would be borne by school agencies.

Subcommittee Staff Recommendation. It is **recommended to (1) approve** the augmentation of $69 million (General Fund) for local assistance, **(2) reject** the DMH positions, and **(3) reject** all of the proposed trailer bill language. Though the Administration has proposed some interesting concepts, discussions need to continue with all involved constituency groups. As such, rejection of the trailer bill language will require all parties to participate in the crafting of language to restructure the program. The assumed establishment of a categorical program by July 1, 2006 is not viable, nor is the suspension of the mandate for two years until a more comprehensive approach is crafted and has time to be implemented.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. DMH, Please provide a brief summary of the proposal.

2. Early, Periodic Screening, Diagnosis & Treatment—*Baseline & Audit Concerns*

May Revision The May Revision proposes **(1)** a *decrease* of $27 million ($12.1 million General Fund) in the current year, and **(2)** a *decrease* of $12.9 million ($5.9 million General Fund) for 2006-07 for the Early, Periodic Screening, Diagnostic & Treatment (EPSDT) Program.

The May Revision adjustments are technical in nature, *except* for the continued use of the extrapolation process for conducting EPSDT audits. This issue was discussed at length in a prior Subcommittee hearing (March 6th).

Prior Subcommittee Hearing—Concerns with Extrapolation. In the Subcommittee's March 6th hearing, considerable discussion occurred regarding the DMH's revised audit process and their use of "extrapolation" of audit data. Numerous constituency groups testified regarding the lack of clarity on how the extrapolation process is to be applied, the lack of credible sampling strategies and many other issues as noted below in the background section.

The result of the hearing was that the DMH was to work with constituency groups to recraft and retool their process and *report back* to the Subcommittee.

Status of Recrafting is Still a Work Process. It is the understanding of Subcommittee staff that no resolution has been reached, nor has the DMH as yet decided on how it may choose to proceed. **The DMH is still reviewing options and needs to further engage the constituency committee on a number of issues.**

Background--Constituency Concerns with Use of Extrapolation of Audit Data. As part of a series of cost containment actions over several years, effective January 2005, the DMH hired a consultant to commence chart audits of EPSDT services using a revised audit methodology.

Though EPSDT audits have been conducted previously, these newer audits use an "*extrapolation" method* which is then applied across those services provided by the audited "legal entity". It is the application of this "extrapolation" method that has raised the most concerns of many constituency groups.

Under the DMH extrapolation method, the audit contractor selects a statistically valid sample of case files from a particular provider to review. *Any* audit disallowances resulting from this sample of this one provider are then extrapolated to *all* of the said agency's (i.e., legal entity) other mental health treatment clinics/service providers. As such, a small number of cases are then applied to the *entire* agency (all of the providers affiliated with the agency). Therefore, a few hundred dollars of audit disallowances from one provider can then become thousands of dollars of disallowances to the agency (legal entity) under this extrapolation method.

According to the DMH, with the use of extrapolation for each $100 in claims that are disallowed, DMH has recouped $5,000 (on average). Therefore a legal entity could estimate its total dollars to be recouped by multiplying the dollar amount of the claims disallowed by 50. Further, if the DMH did *not* do extrapolation, only about 2 percent would be recouped. It should be noted that there are 40 pending audit appeals currently being tracked by the DMH since inception of this revised audit method.

A core concern of the extrapolation method is its validity. An agency (legal entity) can have different facilities which provide different services and serve different populations. As such, auditing one facility and extrapolating to others can give misleading results. Further, extrapolation is done by service function (such as therapy service, medication management, case management) but there is not a statistically valid sample for each service function at the level of the legal entity. For example, 50 charts are audited from one provider and the results could represent less than 1 percent of the claims for a particular service (i.e., for the agency/legal entity as a whole).

Through a series of meetings and letters, many organizations, including the CA Council of Community Mental Health Agencies, California Alliance of Child and Family Services, and County Mental Health Directors Association, have expressed their concerns to the DMH about the extrapolation method of auditing.

Numerous issues have been raised regarding the use of the extrapolation method, as discussed above, as well as several other issues including the following:

- **Lack of guidance** from the state to the counties and to the providers regarding the use of certain reimbursement codes under the program, particularly case management services.
- Use of the **"Disallowance Claims System" needs to be revamped.** Under this system a provider can request a County Mental Health Plan to remove a request for reimbursement (claim for services) from the billing system prior to any formal audit disallowance. Since the request for billing has been removed, the claim is not reviewed as part of the audit process.
- Concern that these revised audits are causing an administrative burden while not addressing any issues related to concerns of inadequate service capacity as raised through litigation in prior years (See Additional Background Section, below).

Additional Background Information on How the EPSDT Program Operates. Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

In 1990, a national study found that California ranked 50th among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Belshe' 1994), the DHS was required to expand certain EPSDT services, including outpatient mental health services.** The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.

County Mental Health Plans must use a portion of their County Realignment Funds to support the EPSDT Program. Specifically, a "baseline" amount was established as part of an interagency agreement in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002. **As such counties must provide about $77.3 million in County Realignment Funds to support the EPSDT Program in 2006-07.**

Subcommittee Staff Recommendation. Significant issues continue to swirl regarding the use of extrapolation, its statistical validity and various other issues. (Subcommittee staff has a 25 page document on issues.) It has been difficult to engage the Administration on these issues and as such, it is recommended to adopt the following uncodified trailer bill language to provide a process for resolving them in a timely manner.

Uncodified trailer bill:

> It is the intent of the Legislature that the Department of Mental Health (DMH) shall revise, or in the alternative, discontinue its current method for extrapolating from the results of audits of legal entities of specialty mental health services expenditures to determine audit disallowances under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. As part of this process, the DMH shall regularly meet with involved constituency providers to clarify billing rules, statistical validity and related concerns with the extrapolation process and/or to discuss an alternative process to replace it.
>
> Effective August 1, 2006, if the Director of the Department of Finance (DOF) has not provided written notification to the Chair of the Joint Legislative Budget Committee (JLBC) that the DMH has revised its current method for determining EPSDT audit disallowances, the Director of the DMH shall cease using the extrapolation method for determining audit disallowances. Further use by the DMH of the current extrapolation method for determining audit disallowances shall not occur any sooner than 30 days, or any lesser time as determined by the Chair of the JLBC, after the Director of the DOF has provided written notification in advance to the Chair of the JLBC as specified in this section that DMH has revised its current extrapolation method for determining audit disallowances. Nothing in this section shall prevent the DMH from conducting standard audits of the EPSDT Program as done prior to changes made in 2004.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH,** Please provide the Subcommittee with an update on this issue .

3. Licensing and Certification of Mental Health Facilities *(See Hand Out)*

Issue. The budget **proposes an increase of $420,000** (reduction of $401,000 General Fund and an increase of $349,000 Licensing and Certification Funds in the DMH item, and an increase of $71,000 federal funds) **to fund 5 new positions to conduct increased monitoring of 165 mental health facilities (i.e., 24-hour psychiatric and rehabilitation care facilities).** It is the Administration's intent to fund these positions with fees deposited into a special fund as created by trailer bill legislation. The table below shows the fee structure.

It should be noted that though the DMH had statutory authority to begin charging fees to Mental Health Rehabilitation Centers (MHRCs) beginning as of January 1, 2005, no fee structure has been proposed until now. As such, MHRCs would be paying licensing and certification fees for

the first time. **Second, for unknown reasons the DMH stopped collecting licensing and certification fees from Psychiatric Health Facilities (PHFs) beginning in 2000. The DMH finally identified this problem and will commence collecting fees again in the budget year.**

The DMH states that the fees, as shown below, were set by taking the total staff costs involved in completing MHRC and PHF licensing surveys and dividing the number of beds into that total to determine the per bed fees of $197 and $170 respectively.

Table: DMH Fee Structure for 2006-07

Type of Facility	# of Facilities	Total Beds	Fee per Bed	Revenue
Mental Health Rehabilitation Center	23	1,700 beds	$197	$335,000
Psychiatric Health Facility	18	389 beds (119 private) (270 public)	$170	$66,000 ($20,000 private) ($46,000 public)
Total				$401,000

The five positions and their key functions are as follows:

Facility License and Program Certification (Two Positions). These two positions-- a Staff Mental Health Specialist and Associate Mental Health Specialist—would be used to conduct additional facility license and program certification functions.

Program Investigations (Three Positions). These three positions—a Consulting Psychologist, Associate Mental Health Specialist, and Office Technician—would be used to respond to requests for investigations of violations and to investigate serious incidents reported by facilities.

Background—DMH L & C Responsibilities. The DMH has **lead** responsibilities for the licensing and certifying of 24-hour Psychiatric Health Facilities (PHFs), and Mental Health Rehabilitation Centers (MHRCs). In addition, the DMH is responsible for criminal background checks of staff employed or contracted by 42 facilities licensed by the department.

Subcommittee Staff Recommendation. It is **recommended to approve the requested five positions but to reject the proposed trailer bill legislation and instead, adopt placeholder trailer bill legislation that would establish a special fund and provide for fee adjustments as necessary to fund the request, *except* for public facilities (keep them exempt). It is also recommended to provide an increase of $46,000 General Fund to appropriate fund the proposal (needed if exemption is given for the public facilities).** The workload for the positions is justified and there is a definitive need for them in order to assure patient care and protection.

The DMH however has not proactively contacted constituency groups regarding their January budget proposal but will now be convening a stakeholders meeting on May 26th. As such**, *placeholder language*** is appropriate in order to maintain flexibility to make changes through Conference Committee.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. **DMH,** Please provide a brief summary of the request.

STATE HOSPITAL ISSUES

Overall Background—Summary of State Hospital Patients & Funding: The department directly administers the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga (to be activated). In addition, the DMH administers acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison.

Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans (County MHPs) contract with the state to purchase beds. County MHPs reimburse the state for these beds using County Realignment Funds (Mental Health Subaccount). **Judicially committed patients are treated solely using state General Fund support.**

Governor's May Revision The May Revision proposes numerous adjustments for the State Hospitals for a *net* increase of $135,000 (an increase of $7.380 million General Fund). Total expenditures for the State Hospitals are now estimated to be $884.9 million ($771.8 million General Fund) for 2006-07. **This represents a series of adjustments related to court rulings, caseload changes and related items.**

The May Revision caseload assumes a budget-year population of **5,805 patients for 2006-07** (as of June 30, 2006). Of this total caseload, only 520 patients are committed by County Mental Health Plans. The remaining 5,285 patients are penal-code related patients (618 are SVP patients).

Each of the May Revision issues is discussed below.

- *Current Year Judicially Committee/Penal Code Population Adjustment (issue 101)*. A **reduction of $16.3 million** (General Fund) and 178.5 positions is requested for the current-year to reflect a reduction in the Judicially Committed/Penal Code population of 195 patients, including a decrease of 46 Incompetent to Stand Trial (IST), 11 Not-Guilty by Reason of Insanity (NGI), 67 Mentally Disordered Offenders (MDOs), and 71 Sexually Violent Predators (SVPs). **No issues have been raised regarding this adjustment.**

- *Budget Year Judicially Committed/Penal Code Population Adjustment (issue 100).* An increase of $4.232 million and 42.5 positions to reflect a net increase in the Judicially Committed/Penal Code population of 158 patients, including 9 IST patients, 65 MDO patients, and 75 SVP patients. This adjustment reflects the use of the new Civil Rights for Institutionalized Persons Act staffing standards/ratios. **No issues have been raised regarding this adjustment.**

- *Additional Staff for Residential Housing Units at Coalinga State Hospital (issue 105).* An increase of $1.776 million and 24.5 positions is requested for a change in the staffing needs identified in the Sexually Violent Predator Treatment Restructure savings proposal included in the Budget Act of 2005. This request is based on the DMH's experience in activating residential housing units at Coalinga State Hospital and the need for Level-Of-Care staffing. **The LAO recommends reducing this request by $888,000 (General Fund), or half-year funding since the DMH has had recruiting difficulties at Coalinga. Therefore the LAO believes this reduced level of funding is more realistic. Subcommittee staff has raised no issues with this request.**

- *Coleman Court-Order: Activation of 36 Intermediate Care Facility (ICF) Beds at Salinas Valley State Prison (issue 102).* An increase of $5.650 million (General Fund) and 68.2 positions is requested to reflect the December 2006 activation of an additional 36 temporary ICF beds at Salinas Valley State Prison. This adjustment is needed to address the Coleman case (pertains to the CA Department of Corrections and Rehabilitation (CDCR) providing appropriate mental health treatment to individuals). **No issues have been raised regarding this adjustment.**

- *Coleman Court-Order: Conversion of 60 Day Treatment Bed to 36 Intermediate Care Facility (ICF) Beds (issue 103).* An increase of $1.8 million (General Fund) and 19.3 positions is requested to reflect the full-year impact of the current-year reduction in the CDCR population of 24 patients. This reflects the impact of the Coleman court order to convert 60 Day Treatment beds to 36 ICF beds at Vacaville Psychiatric Program. Additional staff resources are necessary because the staff-to-patient ratios for an intensive inpatient 24-hour ICF program are significantly higher than an outpatient day treatment program. **No issues have been raised regarding this adjustment.**

- *Coleman Court-Order: Establish a New Psychiatrist Series at Vacaville Psychiatric Program and Salinas Valley Psychiatric Program (issue 104).* An increase of $432,000 (General Fund) is requested to reflect the establishment of a new psychiatrist series classification at Vacaville and Salinas Valley Psychiatric Programs. This funding will be used to provide a ten percent base salary increase and a one-time bonus of $5,000 after the first six-months to new employees hired from outside state service. This adjustment is requested to address a court order in the Coleman case. **No issues have been raised regarding this adjustment.**

- *Permanent General Fund Shift from the Department of Health Services (issue 106).* An increase of $9.745 million (General Fund) and a decrease of $7.245 million (Reimbursements) is requested to reflect the permanent shift of General Fund support from the DHS to the DMH for patient generated revenue and eligibility unit contracts at Metropolitan State Hospital and Napa State Hospital. This adjustment conforms to other adjustments from the January budget that had previously been approved by the Subcommittee. **No issues have been raised regarding this adjustment.**

- *Technical Adjustment to Correct Scheduling Error (issue 111).* The Department of Finance is requesting an adjustment to correct a technical scheduling error which will shift $6.688 million within the State Hospital Item to fund an increase of 125 CDCR patients. There is no impact to the budget authority for this Item. **No issues have been raised regarding this adjustment.**

2. Office of Patient Rights to Monitor and Assist Patients at the State Hospitals

Issue: The Subcommittee is in receipt of a request **to provide $341,288 (General Fund)** to the Office of Patient Rights within the DMH for the contract services that provide patient's rights advocacy services so they may provide.

Constituency concerns have been raised regarding this issue because of the ever increasing caseload at the State Hospitals, as noted above, and the complexity of the patient population (about 90 percent penal code, many with violent behaviors).

In addition, California must now implement the many requirements of the Civil Rights of Institutionalized Persons Act (CRIPA).

Under state and federal law, State Hospitals are required to have a compliant process which allows patients to file complaints that their rights have been violated, including conditions of their care. State law requires that the Patient Right's Contractor take action within two days to investigate each complaint.

The lack of having an adequate number of advocates at each State Hospital make it difficult to comply with these requirements and pose a risk that residents could challenge the DMH's failure to provide advocacy services which are compliant with state and federal law.

The Patient Right's Contractor assists in the licensing reviews and advises the DMH on the plans of corrections required by the Department of Health Services (DHS). The DHS has the authority to impose financial fines for patients' rights violations. Therefore, it is in the best interest of the DMH to want to have a fully operational Patient Right's contract.

Several of the issues identified in the CRIPA report had previously been raised by the independent Patient's Rights contractor. Proactive involvement by the contractor, as well as responding to specific patient complaints, assists the DMH in developing policies and procedures which address deficiencies identified in the DOJ reports.

Subcommittee Staff Recommendation: It is recommended to increase by $341,288 (General Fund) to provide for three additional Supervising Advocate Specialist I' and one additional Patient's Rights Specialists. This is a modest increase that can go along way and quite frankly is overdue and should have been addressed by the Administration.

Questions: The Subcommittee has requested the DMH to provide technical assistance regarding this issue by responding to the following questions.

1. DMH, Please provide a brief summary of the functions of the Patient's Rights Contractor. Are these services effective?